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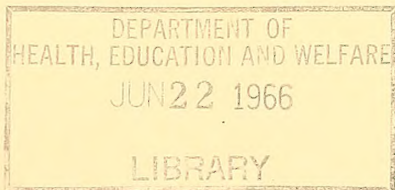
HEALTH  
INSURANCE  
FOR THE AGED



U.S. DEPARTMENT OF  
HEALTH, EDUCATION, AND WELFARE  
SOCIAL SECURITY ADMINISTRATION

HIM-11 (6-66)

HOME  
HEALTH  
AGENCY  
MANUAL







# Health Insurance for the Aged

## HOME HEALTH AGENCY MANUAL

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### USING THE HOME HEALTH AGENCY MANUAL

#### *Use It for Reference*

The manual covers not only routine information for your day-to-day operations but tries to anticipate infrequent situations that could occur. Use it for reference.

#### *Keep It Available*

Pages are punched for any standard-size 3-ring hardback binder. Keep it handy and ask for as many extra copies as you need.

#### *Keep It Up-to-Date*

Insert or replacement pages for additions and revisions will be furnished through your intermediary. Maintain a control on all manuals to assure immediate updating.

#### *Use Chapter Subjects*

A detailed index to facilitate locating of specific information will be sent later. The general subject listing for each chapter will help by giving designated section heads.

# HOME REPAIRS

1. Check the water supply to the house. The main water valve should be open. Check the water meter for leaks. If the water is not flowing, check the water pressure. If the pressure is low, there may be a problem with the water supply line.

2. Check the electrical system. Make sure the circuit breakers are not tripped. Check the fuses in the fuse box. If the lights are not working, check the bulbs. If the outlets are not working, check the wiring.

3. Check the plumbing. Look for leaks under the sink, around the toilet, and in the basement. If there is a leak, turn off the water and call a plumber. Check the water heater for leaks. If the water heater is leaking, it may need to be replaced.

4. Check the roof. Look for missing shingles, damaged gutters, and leaks. If there is a leak, call a roofer. Check the foundation for cracks. If there are cracks, call a foundation repair company.



## FOREWORD

This manual is designed for use by home health agencies which will be billing for services furnished under the provisions of the Health Insurance for the Aged Act of 1965. It contains informational and procedural material the home health agency will need to assist in prompt and efficient payment of claims and to answer questions which patients may ask about the program. This issuance should help to assure that the law is uniformly applied nationally without regard to where covered services are furnished. This manual is not intended to supersede "The Conditions of Participation for Home Health Agencies." Both issuances are to be used for home health agency reference purposes. The home health agency's intermediary will issue any necessary supplementary instructions on matters which concern the relationship between agencies and intermediaries.

The manual does not have the effect of regulations, but a careful effort has been made to insure that the provisions of the law and proposed regulations are accurately reflected.

The procedures described in this manual have been devised to satisfy the administrative needs of the program with a minimum of inconvenience to beneficiaries, and to home health agencies and their intermediaries. We believe that the vast majority of claims will lend themselves to simple, routine handling.

The manual is designed to accommodate new pages as further interpretations of the law and changes in procedures are made. Accordingly, revised sections, pages or chapters will be issued as the need presents itself.

Your intermediary will answer any questions you may have about policies and procedures in the program. Home health agencies dealing directly with the Social Security Administration may direct any questions to the servicing social security district office for reply or refer them to the Bureau of Health Insurance Regional Representative.

ARTHUR E. HESS, *Director,*  
US, *Bureau of Health Insurance.* /



# CHAPTER I

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## Chapter I

# GENERAL INFORMATION ABOUT THE PROGRAM

### 100. INTRODUCTION

The Health Insurance for the Aged Act, Title XVIII of the Social Security Act has made available to nearly every American 65 years of age and older a broad program of health insurance designed to assist the Nation's elderly to meet hospital, medical, and other health costs. The program includes two related health insurance programs—hospital insurance (Part A of the law) and voluntary supplementary medical insurance (Part B of the law).

The conduct of the program has been delegated by the Secretary of Health, Education, and Welfare to the Commissioner of Social Security. Congress has provided substantial administrative roles for the States and for voluntary insurance organizations in recognition of their experience in the health care and insurance fields.

The law specifically prohibits the Federal Government from exercising supervision or control over the practice of medicine, the manner in which medical services are provided, and the administration or operation of medical facilities. The patient is free to choose any qualified institution, agency, or person offering him services. The responsibility for his treatment and the control of his care remains with his physician and the home health agency or other facility furnishing him services. The individual may keep or obtain any other health insurance he desires.

### 102. DISCRIMINATION PROHIBITED

Participating providers of services under the hospital insurance program, i.e., hospitals, extended care facilities, and home health agencies, must comply with the requirements of Title VI of the Civil Rights Act of 1964. Under the provisions of that Act, a participating home health agency is prohibited from making a distinction on the ground of race, color, or national origin in the acceptance and treatment of patients; the services provided; the use of equipment and other facilities; and the assignment of personnel to provide services.

The Department of Health, Education, and Welfare is responsible for investigating complaints of noncompliance.

### 104. DISCLOSURE OF INFORMATION

Records and information acquired in the administration of the Social Security Act are confidential and may be disclosed only under the conditions prescribed in regulations or on the express authorization of the Commissioner of Social Security. The regulations of the Department of Health, Education, and Welfare regarding the confidentiality of records and information apply not only to governmental agencies but also to public and private agencies participating in the administration of the program, as well as those institutions, facilities, agencies, and persons providing services, and those furnishing services under arrangements with a provider of services. However, the medical records of a patient (other than those obtained from the Social Security Administration) are the property of the home health agency and are not subject to these rules and regulations even though the patient receives benefits under this program. These records, however, may be subject to State or local laws or home health agency rules governing disclosure.

Disclosure by a provider of records or information is permitted when necessary in connection with a claim under health insurance and for the proper performance of the duties of any officer or employee of a public or private agency, or organization which has entered into an agreement with the Social Security Administration to carry out the health insurance provisions of the law.

Program information furnished by a provider of services to a State agency certifying providers in the health insurance program may, with the approval of the Department of Health, Education, and Welfare be disclosed by the State agency to the State licensing authority if the information relates to the provider's compliance or noncompliance with the licensure requirements.

Program information and records may not be disclosed to others not enumerated above except under the conditions prescribed by regulations.

### 110. HOSPITAL INSURANCE—A BRIEF DESCRIPTION

Payment for the services and items provided under hospital insurance described below is always made directly to the provider of service; i.e., hospital, extended

care facility, or home health agency, on behalf of the patient. The amount of such payment is based on the reasonable cost to the provider for furnishing these covered services and items to the patient.

**110.1 Inpatient Hospital Services.**—The items and services covered include: bed and board in a semi-private (2 to 4 beds) accommodation, unless a private room is medically necessary; nursing and other related services; use of hospital facilities and medical social services ordinarily furnished by the hospital for the care and treatment of inpatients; drugs, biologicals, supplies, appliances, and equipment for use in the hospital, which are ordinarily furnished by the hospital; diagnostic or therapeutic items or services furnished by the hospital or by others under arrangements made by the hospital; services by interns or residents-in-training if they are under a teaching program approved by the American Medical Association, American Osteopathic Association, or American Dental Association; and cost of whole blood after the first 3 pints in a spell of illness and all costs of administering the blood.

The patient is entitled to payment on his behalf for up to 90 days of inpatient hospital services in each spell of illness. There is an inpatient hospital deductible of \$40 in each spell of illness and a coinsurance amount of \$10 per day after the 60th day and through the 90th day. The deductible and coinsurance amounts are subject to change on January 1, 1969, and on the first day of each odd year thereafter.

Inpatient tuberculosis hospital services are covered if the services furnished to the individual are services which can reasonably be expected to improve his condition or render it noncommunicable. Inpatient psychiatric hospital services are covered if the services furnished to the patient are furnished when he is receiving intensive treatment, or are necessary for medically required inpatient diagnostic study. Where an individual is in a qualified tuberculosis or psychiatric hospital on the first day of the first month for which he is entitled to hospital insurance benefits, the days on which he was an inpatient of such a hospital in the 90-day period immediately before his first day of entitlement must be counted in determining the 90-day limit on inpatient hospital services in his first spell of illness. In addition, there is a lifetime limitation of 190 days for payment for inpatient psychiatric hospital services. A period spent in a psychiatric hospital prior to entitlement, however, does not count against the 190 days.

**110.2 Outpatient Hospital Diagnostic Services.**—Outpatient hospital diagnostic services covered under hospital insurance include—

A. diagnostic tests and related services to the extent that they would not be excluded if performed on an inpatient basis;

B. drugs and biologicals necessary for diagnostic study;

C. the services rendered in connection with a diagnostic study by an intern or resident-in-training under an approved teaching program; and

D. other services and supplies if customarily furnished to outpatients for purposes of diagnostic study.

Benefits are payable on the basis of a diagnostic study period, which is a period of 20 consecutive days beginning with the first day, not included in a previous diagnostic study, on which the patient receives outpatient diagnostic services.

The **deductible** for outpatient hospital diagnostic services during each diagnostic study is one-half the inpatient hospital deductible, or \$20. This deductible amount counts as an incurred expense for individuals with supplementary medical insurance coverage. After satisfying the \$20 deductible, the patient is responsible for a coinsurance amount equal to 20 percent of the reasonable charges, not in excess of the amount customarily charged, for the outpatient hospital diagnostic services rendered during the diagnostic study.

**110.3 Posthospital Extended Care Services.**—A patient is entitled to up to 100 days of posthospital extended care services in a spell of illness. The patient must have been a hospital inpatient for at least 3 consecutive ~~calendar~~ days before his discharge and must be admitted to the extended care facility within 14 calendar days after the date of hospital discharge. Benefits for posthospital extended care are payable for services furnished on or after January 1, 1967. Discharge from the hospital must occur after June 30, 1966, or on or after the first day of the month in which the beneficiary attains age 65, whichever is later. The program will pay the reasonable cost of services for up to 100 days in each spell of illness, except that there is a \$5 per day coinsurance amount for each day of extended care services after the first 20 days.

Covered services include room and board; skilled nursing care by or under the supervision of a registered professional nurse; physical, occupational, or speech therapy either by the extended care facility or under arrangements made by the facility; drugs, biologicals, supplies, appliances, and equipment furnished for use in the extended care facility which are ordinarily furnished for the care and treatment of inpatients; and other services ordinarily furnished by the facility. No payment may be made for custodial care or for items or services which would not be covered in a hospital, e.g., physicians' services and private duty nursing. The services of residents-in-training and interns under an approved teaching program of a hospital with which the facility has a transfer agreement (see § 112.2), and other diagnostic and therapeutic services furnished by such a hospital are covered if furnished under arrangements made by the facility.

**110.4 Posthospital Home Health Services.**—Home health services are provided under hospital in-



surance and also under supplementary medical insurance. (For a complete discussion of these services, see chapter II.)

## 112. HOSPITAL INSURANCE DEFINITIONS RELATING TO PART A HOME HEALTH SERVICES

**112.1 Hospital.**—A hospital is an institution which—

A. is primarily engaged in providing, by or under the supervision of physicians, to inpatients—

1. diagnostic and therapeutic services for medical diagnosis, treatment, and care of injured, disabled, or sick persons, or

2. rehabilitation services for the rehabilitation of injured, disabled, or sick persons.

B. maintains clinical records on all patients;

C. has bylaws in effect concerning its staff of physicians;

D. has a requirement that every patient must be under the care of a physician;

E. provides 24-hour nursing service by or supervised by a registered professional nurse and has a licensed practical nurse or registered professional nurse on duty at all times;

F. has in effect a hospital utilization review plan;

G. is licensed or is approved by the State or local licensing agency as meeting the standards established for such licensing; and

H. meets other health and safety requirements of the Secretary of the Department of Health, Education, and Welfare. (These additional requirements may not be higher than comparable ones prescribed for accreditation by the Joint Commission on Accreditation of Hospitals with certain exceptions specified in the law.)

I. is not primarily for the care and treatment of mental diseases or tuberculosis.

**112.2 Extended Care Facility.**—An extended care facility is one which provides skilled nursing care and related services for patients who require medical or nursing care; or rehabilitation services for injured, disabled, or sick persons. It may be either a separate institution (such as a nursing home) or a part of an institution (such as a convalescent wing of a hospital), licensed or approved for licensing under State or local law, and meet the health and safety conditions prescribed by the Secretary of the Department of Health, Education, and Welfare. The extended care facility must have a written transfer agreement with one or more participating hospitals providing for the transfer of patients between the hospital and the facility and for the interchange of medical and other information. If an otherwise qualified facility has failed in an attempt, in good faith, to enter into such an agreement, the agreement requirement may be waived by the State agency. A facility primarily for the care and treat-

ment of mental disease or tuberculosis may not qualify as a participating extended care facility in the health insurance program.

Qualified facilities must enter into the required agreement with the Secretary to participate as providers of services in the health insurance program.

A patient can meet the prior stay requirement for "posthospital" home health services (see chapter II) by a covered stay in a participating extended care facility. See § 110.3 for the conditions of a covered stay.

**112.3 Spell of Illness Defined.**—A spell of illness is a period of consecutive days that **begins** with the first day (not included in a previous spell of illness) on which a patient is furnished inpatient hospital or extended care services by a qualified provider in a month for which the patient is entitled to hospital insurance benefits. A qualified hospital (including a psychiatric or tuberculosis hospital) or extended care facility is one that has been certified as meeting all the requirements of the definition of such an institution. A hospital which meets the requirements in the definition of a hospital except for F and H in § 112.1 is also a qualified hospital for purposes of beginning a spell of illness when such hospital furnishes the patient covered *inpatient emergency* services. **Thus, generally, the spell of illness begins when covered inpatient services are initially furnished to an entitled individual.**

The spell of illness **ends** with the close of a period of 60 consecutive days during which the patient was neither an inpatient of a hospital nor an inpatient of an extended care facility. **It is important to note that for purposes of continuing a spell of illness, the hospital or extended care facility in which the stay occurs need not meet all of the requirements that are necessary for starting a spell of illness.**

Inpatient services will prolong the beneficiary's spell of illness if the **hospital** is primarily engaged in providing, by or under the supervision of physician(s), to inpatients (1) diagnostic and therapeutic services for medical diagnosis, treatment, and care of injured, disabled, or sick persons, or rehabilitation services for injured, disabled, or sick persons; **or** (2) psychiatric services for the diagnosis and treatment of mentally ill persons; **or** (3) medical services for the diagnosis and treatment of tuberculosis.

Similarly, inpatient services in an **extended care facility** will prolong a beneficiary's spell of illness if the facility (including one primarily for the care and treatment of mental diseases or tuberculosis) meets at least the requirement that it is primarily engaged in providing to inpatients skilled nursing care and related services for patients who require medical or nursing care, or rehabilitation services for injured, disabled, or sick persons.

An individual may be discharged from and re-admitted to a hospital or extended care facility several times during a spell of illness and still be in the same spell if 60 days have not elapsed between discharge and readmission. The stay need not be for related physical or mental conditions.

As long as a person continues to be entitled to hospital insurance, there is no limit to the number of spells of illness he may have.

**Example 1:** X was born August 9, 1902. On July 28, 1967, X entered a participating general hospital. After he had been in the hospital for 2 weeks X was discharged on August 11, 1967. On his doctor's orders X entered a participating nursing home on August 15, 1967, and remained there until his discharge on October 27, 1967. He had no further inpatient stays in 1967. X's spell of illness began on August 1, 1967, the first day of the month he attained age 65 and was entitled to hospital insurance. The spell of illness ended December 26, 1967, 60 days after his last discharge.

**Example 2:** Y, over age 65, entered a participating general hospital on July 28, 1968, for treatment of a heart condition. He was discharged on August 11, 1968. On August 20, 1968, Y entered a **nonparticipating nursing home**, which provided primarily skilled nursing care and related services. Y remained in this facility until his discharge on October 27, 1968. On December 25, 1968, Y was again admitted to a participating hospital because of injuries suffered in an accident. He was discharged on January 13, 1969, and had no further inpatient stays in 1969. Y's spell of illness began on July 28, 1968. His stay in the nursing home began less than 60 days after his hospital discharge and the spell was continued even though the stay was not covered. The subsequent hospital stay began less than 60 days after the nursing home discharge and continued the spell of illness although the condition treated was unrelated to his prior stays. The spell ended on March 14, 1969.

## 115. SUPPLEMENTARY MEDICAL INSURANCE—A BRIEF DESCRIPTION

**115.1 Benefits.**—The voluntary medical insurance plan is designed to supplement the basic hospital insurance coverage. It provides coverage effective July 1, 1966, for (a) home health services (a full discussion of the coverage under this phase of the program is contained in chapter II), and (b) medical and other health services.

Medical and other health services include:

A. Physicians' services (see definition of "physician" below) including surgery, consultation, and home, office, and institutional calls.

Regardless of the actual expenses for physician services incurred in the treatment of mental, psychoneurotic, or personality disorders of persons who are not

inpatients of hospitals, the amount of such expenses that can be counted in a calendar year is limited to the lesser of \$312.50 or 62.5 percent of the actual expenses.

**Physician** means a doctor of medicine or osteopathy (including osteopathic practitioner) legally authorized to practice by a State in which he performs the function or action. A doctor of dental surgery or dental medicine having State authorization to practice is also defined as a physician but only for surgery related to the jaw or any structure contiguous to the jaw, or the reduction of a fracture of the jaw or any facial bone. (These services must be services that could be performed by either a qualified physician or dentist; routine dental care is not included.) The services performed by physicians within these definitions are subject to any limitations imposed by the State on the scope of practice.

B. Services and supplies (including drugs and biologicals which cannot be self-administered) incident to physicians' professional services and of kinds commonly furnished by a physician in his office and which are commonly rendered without charge or included in his bill. The services include hospital services (including drugs and biologicals which cannot be self-administered) incident to physicians' services rendered to outpatients.

C. Diagnostic X-ray, laboratory, and other diagnostic tests.

D. X-ray, radium, and radioactive isotope therapy (including material and services of technicians).

E. Surgical dressings, and splints, casts, and other devices used for reduction of fractures and dislocations.

F. Rental (for use in the patient's residence, including an institution used as his home) of such durable medical equipment as iron lungs, oxygen tents, wheelchairs, and special beds.

G. Ambulance service, where the use of other transportation is contraindicated by the patient's condition. (Transportation service from place of residence to a facility to receive home health services on an outpatient basis is excluded.)

H. Prosthetic devices (other than dental) replacing all or part of an internal body organ, including replacement of such devices.

I. Leg, arm, back, and neck braces, and artificial legs, arms, and eyes, including replacements if required because of a change in physical condition.

**115.2 Basis for Payment.**—Payment, based on **reasonable charges**, may be made to or on behalf of individuals covered by medical insurance for services of physicians and other nonprovider services furnished under the plan. In determining the reasonableness of charges the carrier takes into consideration the customary charges of the physician (or other person rendering the service) as well as the prevailing charges in the locality generally made for similar services. A



charge is not reasonable if it is higher than the charge applicable for a comparable service and under comparable circumstances to the intermediary's own policyholders or subscribers.

Payment for services rendered by or under arrangements made by a home health agency or other provider of services under medical insurance is based on the **reasonable cost** of the services and is made only to the provider of services. This is the same basis for reimbursement as under the hospital insurance plan and accords with the provider's undertaking in the participation agreement to accept reasonable cost as full payment for services rendered.

**115.3 Deductible and Coinsurance.**—There is a deductible consisting of the first \$50 of covered incurred expenses in a calendar year (expenses applied toward the deductible in the last 3 months of a year may also be applied toward the deductible in the following year). After the deductible has been satisfied, payment by the supplementary medical insurance program will be made for 80 percent of the reasonable charge or cost.

## **120. ENTITLEMENT TO HOSPITAL INSURANCE**

A. An individual is **automatically** entitled to hospital insurance beginning with the first day of the month he attains age 65 if he has applied for and been determined to be entitled to monthly social security benefits (although he may not actually be receiving benefit payments, e.g., he has not retired). Automatic entitlement also extends to qualified beneficiaries under the Railroad Retirement Act. (For social security purposes, a person attains age 65 on the day before his 65th birthday.) Example: If birth date is August 1, attainment date is July 31, and health insurance entitlement date is July 1.

A social security applicant who applies for monthly benefits after the month he reaches age 65 is entitled to retroactive hospital insurance benefits beginning with the first month in which he had attained age 65 and met all the requirements for monthly benefits, but not for more than 12 months before the month in which he filed his application.

Entitlement to hospital insurance benefits ends with the month the individual ceases to be entitled to social security monthly benefits or ceases to be a qualified railroad beneficiary (for example, a woman whose wife's benefits are terminated by divorce). A person who ceases to be a social security or railroad retirement beneficiary but who meets the requirements of the special transitional provision described below may reinstate his hospital insurance by filing a proper application under the transitional provision.

Hospital insurance coverage continues for the month of death, although no monthly cash benefits are payable for that month.

B. A special **transitional** provision in the law permits persons 65 years of age and over, who cannot qualify for monthly social security or railroad retirement benefits, to obtain hospital insurance upon filing application. Such an individual must be a resident of the United States and either a citizen or an alien lawfully admitted for permanent residence who has resided in the United States continuously for 5 years. He may not be an active or retired Federal employee (or spouse of one) who is or could have been covered by the Federal Employees Health Benefit Act of 1959. He may not be a member of a communist organization nor have been convicted of a crime against the security of the United States.

For coverage under the transitional provision, a person attaining age 65 after 1967 must have three quarters of coverage for each year elapsing between 1965 and the year in which he attains age 65.

Hospital insurance under the transitional provision can also be retroactive for as many as 12 months before the month of application, provided the individual meets all the other requirements during the period of retroactivity.

## **122. ENTITLEMENT TO SUPPLEMENTARY MEDICAL INSURANCE**

A. **Enrollment.** To obtain supplementary medical insurance coverage an individual must voluntarily enroll in the plan and pay the required premiums. He is eligible to enroll if he is entitled to hospital insurance benefits or is 65 years of age and otherwise meets the requirements for hospital insurance coverage under the transitional provision of the law. Active or retired Federal employees and their spouses are eligible to enroll whether or not covered under the Federal Employees Health Benefit Act. (For social security purposes an individual attains age 65 on the day before his 65th birthday.)

By agreement, States may enroll in the supplementary medical insurance plan eligible individuals who are receiving money payments under certain public assistance programs. Such persons who are entitled to monthly social security or railroad retirement benefits may be included at the option of the State.

B. **Enrollment Periods.** Enrollment is possible only during specified enrollment periods.

1. During the **initial general enrollment period** an opportunity to enroll was afforded to all eligible persons age 65 and over before March 1, 1966. This enrollment period ended May 31, 1966. (An eligible individual who for good cause failed to enroll before June 1, 1966, may enroll before October 1, 1966.)

2. For persons first eligible on or after March 1, 1966, the **initial enrollment period** is 7 months. It begins 3 calendar months before and ends 3 calendar months after the month in which the individual first meets all enrollment requirements.



3. **General enrollment periods** occur October 1 through December 31 of each odd-numbered year beginning with 1967. Those who failed to enroll during their initial enrollment periods and those whose enrollment has terminated may enroll in these periods.

4. **States which desire to enroll eligible individuals receiving public assistance** must request coverage before January 1968, and enter into an agreement with the Government.

An individual who fails to enroll for medical insurance within the 3-year period after the close of his initial enrollment period may not enroll thereafter.

An individual whose enrollment has terminated may re-enroll only once—in a general enrollment period which begins within 3 years after the termination of his prior enrollment.

Payment may be made for covered services if the individual was enrolled at the time the services were furnished, even though at the time the request for payment is filed with the intermediary his enrollment had been terminated.

**122.1 Premiums.**—Initially, the premium is \$3 per month. The law permits the Secretary of Health, Education, and Welfare to adjust the premium amount if medical costs rise. No increase in the premium is permitted before 1968, and increases thereafter can be no oftener than every 2 years. To take into account the higher cost of insuring older individuals, premiums payable by a person who enrolls after the first enrollment period open to him, or who re-enrolls after his initial enrollment was terminated, are increased by 10 percent for each year he could have been but was not enrolled.

A grace period has been provided for payment of premiums. This period extends for 2 calendar months after the month in which the premium is due.

Social security and railroad retirement beneficiaries and civil service annuitants (except those enrolled by the State as public assistance recipients) who elect to enroll will have the premiums withheld from their monthly checks. The State pays the premiums for the public assistance recipients it enrolls.

Other enrollees must make premium payments directly to the Social Security Administration. Enrollees who make direct premium payment will generally be billed quarterly. However, State or local government organizations, employers, unions, or other organizations may under certain conditions pay premiums for their members as a group.

### 122.2 Beginning of Coverage

A. Enrollment during the initial general enrollment period—coverage begins July 1, 1966.

B. Enrollment during an entitled individual's initial enrollment period—coverage begins:

1. First day of the month in which the individual becomes age 65, if he enrolls **before** the month that he becomes 65.

2. First day of the month following the month that he becomes age 65, if he enrolls **in** the month that he becomes 65.

3. First day of the second month after the month of enrollment, if he enrolls in the month **after** he became age 65.

4. First day of the third month after the month of enrollment, if he enrolls **more than one month after** the month in which he became age 65. (However, individuals who become age 65 in March 1966, and enroll in May 1966, will have coverage effective July 1, 1966).

C. Enrollment during one of the general enrollment periods—coverage begins the following July 1.

D. Enrollment by a State of its welfare recipients—coverage begins on the latest of the following but not later than January 1, 1968:

1. July 1, 1966;

2. First day of the third month after the month of the agreement with the State;

3. First day of the first month in which the individual is both eligible and a member of the group.

4. The date specified in the agreement.

### 122.3 End of Coverage

A. An individual whose medical insurance premiums are being deducted may notify the Social Security Administration in writing during a general enrollment period that he no longer wants medical insurance. His coverage period will be terminated with the close of the year in which his notice is submitted.

B. Enrollment under medical insurance is terminated because of nonpayment of premiums. Termination is effective with the end of the grace period provided for payment of premiums.

C. If an individual is enrolled under a Federal-State agreement, his coverage under the agreement ends on whichever of the following first occurs:

1. The end of the month in which he becomes ineligible (as determined by the State) for welfare money payments; or

2. The end of the month before the first month for which he becomes entitled to monthly social security or railroad retirement benefits, unless the State exercises its option to enroll such welfare recipients; or

3. The month in which the agreement terminates.

If an individual's coverage under a Federal-State enrollment agreement is terminated, his coverage continues without interruption if he is a social security or railroad retirement beneficiary or continues payment of premiums.

D. An individual will have coverage through the month in which he dies.

### **130. FEDERAL GOVERNMENT ADMINISTRATION OF THE HEALTH INSURANCE PROGRAM**

The Department of Health, Education, and Welfare has been given overall responsibility for administration of the hospital insurance and voluntary supplementary medical insurance programs. Three major agencies of the Department—the Social Security Administration, Public Health Service, and Welfare Administration—are involved.

**130.1 The Social Security Administration** has the responsibility for policy formulation and the general management and operational aspects of the program. Briefly, these include: determination of the individual's entitlement to benefits and the nature and duration of services for which benefits may be paid; establishment, maintenance, and administration of agreements with State agencies, providers of services and intermediaries; in consultation with the Public Health Service and the Welfare Administration, the formulation of major policies regarding conditions of participation for providers; the development and maintenance of statistical research and actuarial programs; and the general financial management of the program. The Administration also makes determinations of reasonable costs and amounts to be paid to providers who have elected to deal directly with the Government.

**130.2 The Public Health Service** has the principal responsibility for the professional health aspects of the program. These include: professional consultation and recommendation to the Social Security Administration in development of health and safety, and other guidelines for determining whether providers of services meet the conditions for participation under the program; consultation and advice to State agencies concerning the application of standards for providers, and in the coordination of program activities with other health services and activities in the State; and activities necessary in studying the utilization of hospital and other medical care services under the program.

**130.3. The Welfare Administration** has the primary role in hospital and medical insurance program planning, coordination, and evaluation in matters that affect other federally aided assistance programs; in assisting State agencies to achieve a coordinated approach with other medical care plans under the Social Security Act; and in all aspects of program administration affecting public welfare agencies.

### **131. ADVISORY GROUPS**

The law provides for the appointment of two non-Governmental advisory groups to assist the Secretary.

**131.1 The Health Insurance Benefits Advisory Council**, consisting of persons outstanding in hospital,

medical, and other health activities, and at least one representative of the general public, advises the Secretary on general policy in administering the program and in the formulation of regulations. The Secretary must consult with the Council in determining conditions of participation for providers of services in addition to the requirements specifically enumerated in the law.

**131.2 The National Medical Review Committee** is to be selected from people who are representative of professional organizations and associations in the field of medicine and other individuals who are outstanding in the field of medicine or in related fields. At least one member will represent the general public and a majority of the committee are physicians. The committee studies the utilization of hospital and other medical services under the program and makes any recommendations to the Secretary and to Congress that it considers appropriate.

### **132. STATE AGENCIES**

The States are accorded important administrative functions to the extent that each is willing and able to undertake them by agreement with the Secretary.

**A. Certifications** are made by State agencies to the Department of Health, Education, and Welfare indicating whether hospitals, extended care facilities, home health agencies, and independent laboratories meet and continue to meet their respective conditions of participation. This function is intended to be a natural adjunct to ongoing State activities, such as licensing of health facilities and other standard setting activities.

**B. Consultation** services are rendered by State agencies if their agreements provide for it. Consultation with hospitals, extended care facilities, and home health agencies that need and request assistance to meet the conditions of participation is an integral part of the certification process.

**C. Coordination** by the State relates its activities in the performance of its functions under the program to the various other programs in the State that have to do with payment for health care, quality of care, and distribution of health facilities. Coordination of such activities is designed effectively and economically to utilize existing State facilities and trained personnel and to prevent duplication of effort.

**D. State Agency as a Medical Insurance Intermediary.**—Where a State enters into an agreement with the Government to pay the medical insurance premium on behalf of its aged welfare recipients, as explained in 122B of this chapter, the agreement may provide for a designated State agency to serve as an intermediary on behalf of its welfare recipients.

### **135. HOSPITAL INSURANCE INTERMEDIARIES**

Under the hospital insurance plan, groups or associations of providers, on behalf of their members, may



nominate a national, State, or other public or private agency, or organization to serve as intermediary in the claims process. A member of an association is free, however, to receive payment from an approved intermediary other than its association's nominee, if agreeable to the Social Security Administration and to the intermediary selected. A provider may deal directly with the Social Security Administration.

The law permits the Administration to enter into an agreement with a nominated organization if it finds this to be consistent with effective and efficient administration of the hospital insurance program. The intermediary makes payments to providers for covered items and services on the basis of reasonable cost determinations and assists in the application of safeguards against unnecessary utilization of covered services. The agreement may also call for furnishing consultative services to assist providers to establish and maintain necessary fiscal records and otherwise qualify as providers of services; serving as a center for communicating with providers; and making audits of provider records.

Generally speaking, the Social Security Administration will utilize the services of the hospital insurance intermediary in making payments for home health and other provider services under medical insurance.

#### **137. MEDICAL INSURANCE CARRIERS**

The law requires the Secretary to enter into contracts with carriers selected to serve as intermediaries for the performance of specified administrative functions under the medical insurance program. The prin-

cipal function of this intermediary is to determine whether physicians' charges are reasonable and to make payment. Section 134D of this chapter explains the conditions under which a State agency may act as a supplementary medical insurance intermediary.

#### **140. FINANCING HOSPITAL INSURANCE PROGRAM**

The hospital insurance program is financed through separate payroll contributions paid by employees, employers, and self-employed persons. The proceeds are earmarked for the Federal Hospital Insurance Trust Fund to keep them separate from other social security contributions. The law permits their use only for the payment of hospital insurance benefits and administrative expenses. The cost of providing hospital insurance benefits to persons who are not social security or railroad retirement beneficiaries is met by appropriations to the Federal Hospital Insurance Trust Fund from general revenues.

#### **142. FINANCING SUPPLEMENTARY MEDICAL INSURANCE PROGRAM**

The supplementary medical insurance plan is financed by the monthly premiums of those who enroll under the plan, matched by an equal contribution from general revenues. All premiums and Government contributions for this plan are placed in a separate fund known as the Federal Supplementary Medical Insurance Trust Fund. This fund is devoted exclusively to the payment of medical insurance benefits and administrative expenses.



## CHAPTER II

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## CHAPTER II

### COVERAGE OF HOME HEALTH SERVICES

#### 200. HOME HEALTH AGENCY

A home health agency is a public agency or private organization, or a subdivision of such an agency or organization, which meets the following requirements:

A. It is primarily engaged in providing skilled nursing services and other therapeutic services, such as physical, speech, or occupational therapy, medical social services, and home health aide services. A public or voluntary nonprofit health agency may qualify by—

1. furnishing both skilled nursing and at least one other therapeutic service directly to patients, or

2. furnishing directly either skilled nursing services or at least one other therapeutic service and having arrangements with another public or voluntary nonprofit agency to furnish the services which it does not provide directly.

A proprietary agency can qualify only by providing directly both skilled nursing services and at least one other therapeutic service.

B. It has policies established by a professional group associated with the agency or organization (including at least one physician and at least one registered professional nurse) to govern the services, and provides for supervision of such services by a physician or a registered professional nurse.

C. It maintains clinical records on all patients.

D. It is licensed in accordance with State or local law or is approved by the State or local licensing agency as meeting the licensing standards (where State or local law provides for the licensing of such agencies or organizations).

E. It meets other conditions found by the Secretary of Health, Education, and Welfare to be necessary for health and safety.

A private organization which is not exempt from Federal income taxation under section 501 of the Internal Revenue Code of 1954 (sometimes referred to as a "proprietary" organization) must be licensed pursuant to State law. If the State has no licensing law for such organizations, a proprietary agency cannot participate in the health insurance program.

For services under hospital insurance, the term "home health agency" does not include any agency or organization which is primarily for the care and treatment of mental disease. There is no such restriction under supplementary medical insurance.

**200.1 Subdivision of Agencies.**—When the subdivision of an agency, such as the home care department of a hospital or the nursing division of a health department, wishes to participate as a home health agency, the subdivision must meet the conditions of participation and must maintain records in such a way that subdivision activities and expenditures attributable to services provided under the health insurance program are identifiable.

#### 200.2 Arrangements by Home Health Agencies

A. Arrangements made by a home health agency with others to furnish items or services must be such that receipt of payment by the home health agency for the services (whether in its own right or as agent) discharges the liability of the beneficiary or any other person to pay for the services.

Whether the services and items are furnished by the home health agency itself or by another agency under arrangements made by the home health agency, both must agree not to charge the patient for covered services and items and must also agree to return money incorrectly collected.

There are 3 situations in which a home health agency may have arrangements with another health organization or person to provide home health services to patients:

1. Where an agency or organization, in order to be approved to participate in the program, makes arrangements with another agency or organization to provide the nursing or other therapeutic services which it cannot provide directly.

2. Where an agency or organization, which is already approved for participation, makes arrangements with others to provide services it does not provide.

3. Where an agency or organization, which is already approved for participation, makes arrangements with a hospital, extended care facility, or rehabilitation center for services on an outpatient basis because the services involve the use of equipment which cannot be made available to the patient in his place of residence.

**B. If an agency's subdivision** (acting in its capacity as a home health agency) makes an arrangement with its parent agency for the provision of these items



and/or services there need not be a contract or formal agreement. If, however, the arrangement is made between the home health agency and another provider participating in the health insurance program (hospital, extended care facility, or home health agency), there must be a written statement regarding the services to be provided and the financial arrangements.

**C. If the arrangements are with an agency or organization which is not a qualified provider of services,** there must be a written contract which includes all of the following:

1. A description of the services to be provided.
2. The duration of the agreement and how frequently it is to be reviewed.
3. A description of how personnel will be supervised.
4. A statement that the contracting organization will provide its services in accordance with the plan of treatment established by the patient's physician in conjunction with the home health agency's staff.
5. A description of the contracting organization's standards for personnel, including qualifications, functions, supervision, and inservice training.
6. A description of the method of determining reasonable costs and reimbursements by the home health agency for the specific services to be provided by the contracting organization.
7. An assurance that the contracting organization will comply with Title VI of the Civil Rights Act.

**200.3 Rehabilitation Centers.**—When the services are of such a nature that they cannot be administered at the patient's residence and are administered at a rehabilitation center which is not participating in the program as a hospital, extended care facility, or home health agency, the rehabilitation center must meet certain standards. The physical plant and equipment of such a rehabilitation center must meet all applicable State and local legal requirements for construction, safety, health, and design, including safety, sanitation and fire regulations, building codes, and ordinances.

## **205. COVERED HOME HEALTH SERVICES**

A patient may be eligible for home health service under both hospital insurance and supplementary medical insurance. All services furnished by a home health agency, whether provided directly by the home health agency or under arrangements with others, must be furnished by qualified personnel. The following items and services when provided by the home health agency, or by others under arrangements with the home health agency, are covered under both programs.

**205.1 Part-Time or Intermittent Nursing Care.**—Nursing care is professional nursing service provided by a registered professional nurse preferably a qualified public health nurse, in accordance with a

physician's orders, or the practical nursing service provided by a licensed practical or licensed vocational nurse working under the supervision of a registered professional nurse. (See conditions of participation for home health agencies for qualifications required for nurses.)

Part-time or intermittent care is usually service for a few hours a day several times a week. Occasionally, service for a full day may be provided for a short period when, because of unusual circumstances, neither the alternative of part-time care nor hospitalization is feasible.

## **205.2 Physical, Occupational, and Speech Therapy**

### **A. Physical Therapy**

Physical therapy is service provided in accordance with a physician's orders by or under the supervision of a qualified physical therapist.

A qualified physical therapist is licensed or registered by the State when licensure laws are applicable, and meets the following criteria:

1. Graduation from a physical therapy curriculum approved by the American Physical Therapy Association from 1928 to 1936, or by the Council on Medical Education and Hospitals of the American Medical Association from 1936 to 1960, or by the Council on Medical Education of the American Medical Association in collaboration with the American Physical Therapy Association since 1960; or

2. Membership in the American Physical Therapy Association or registration by the American Registry of Physical Therapists; or

3. If the physical therapist was trained outside the United States:

- a. Graduation since 1928 from a physical therapy curriculum approved in the country in which the curriculum was located, and the curriculum must have been in a country in which there is a member organization of the World Confederation for Physical Therapy; and

- b. Membership in a member organization of the World Confederation for Physical Therapy; and

- c. Completion of 1 year's experience under the supervision of an active member of the American Physical Therapy Association; and

- d. Successful completion of a qualifying examination as prescribed by the American Physical Therapy Association.

An individual who graduated from any school before its physical therapy curriculum was approved by the appropriate organization mentioned in 1. above is not a qualified physical therapist unless, of course, he is a member of the American Physical Therapy Association or is registered by the American Registry of Physical Therapists.

## B. Speech Therapy

Speech therapy, that is service in speech pathology or audiology, is service provided in accordance with a physician's orders and furnished by or under the supervision of a qualified speech therapist.

A qualified speech therapist is one certified by the American Speech and Hearing Association, or who has completed the academic requirements and is in the process of accumulating the necessary supervised work experience required for such certification. (The term "speech therapist" includes a speech pathologist.)

## C. Occupational Therapy

Occupational therapy is service given in accordance with a physician's orders and by or under the supervision of a qualified occupational therapist.

A qualified occupational therapist is one registered by the American Occupational Therapy Association or is a graduate of a program in such therapy approved by the Council on Medical Education of the American Medical Association in collaboration with the American Occupational Therapy Association, and is engaged in the required supervised clinical experience period prerequisite to the registration by the American Occupational Therapy Association.

An occupational therapy assistant is one who works under the supervision of a qualified occupational therapist and has successfully completed a training course approved by the American Occupational Therapy Association, and is certified by that body as a certified occupational therapy assistant.

**205.3 Medical Social Services.**—These services must be under the direction of a physician and must be given by or under the supervision of a qualified medical or psychiatric social worker.

A qualified medical or psychiatric social worker is a graduate of a school of social work accredited by the Council on Social Work Education, and has had social work experience in a hospital, outpatient clinic, medical rehabilitation, or medical care program.

A social work assistant is one who works under the supervision of a qualified medical or psychiatric social worker, and has a baccalaureate degree, and has received or is receiving on-the-job training in medical social service tasks and assignments from the agency.

**205.4 Part-Time or Intermittent Services of a Home Health Aide.**—The services of a home health aide are directed toward the personal care of a patient and are given in accordance with physician's orders and under the supervision of a registered professional nurse, or, if appropriate, a physical, speech, or occupational therapist. The assignment of a home health aide to a particular case must be made in accordance with a plan of treatment. The specific personal care services to be provided by the home health aide must

be determined by a registered professional nurse, and not by the home health aide.

The duties performed are essentially personal health care for the patient, i.e., helping the patient to bathe, get in and out of bed and exercise, retraining the patient in the necessary household skills, assisting him with medications that ordinarily are self-administered and which have been specifically ordered by a physician, and performing incidental household services which are essential to the patient's health care at home and necessary to prevent or postpone institutionalization. The discussion of "part-time or intermittent" services in § 205.1 above is also applicable to home health aides.

**205.5 Medical Supplies (Except for Drugs and Biologicals) and the Use of Medical Appliances.**—Medical supplies are items which are essential to enable the home health agency to carry out effectively in the home the kinds of care which the physician has ordered. Medical supplies include (but are not limited to) gauze, cotton, adhesive bandage, surgical dressings, catheters, surgical gloves, rubbing alcohol, irrigating solutions, intravenous fluids, and oxygen.

Medical appliances are items owned or rented by the home health agency and loaned to the patient to facilitate his treatment and rehabilitation. They include, but are not limited to, such items as bedpans, wheelchairs, crutches, hospital beds, trapeze bars, oxygen tents, intermittent positive pressure machines, and air pressure mattresses.

Drugs and biologicals are excluded from coverage as items or services administered by home health agencies, under either hospital insurance or medical insurance. They may, in certain cases, be covered under medical insurance, when administered by a physician as a part of his professional services and are not capable of being self-administered.

**205.6 Services Of Interns and Residents-In-Training.**—These are medical services of interns and residents-in-training under an approved hospital teaching program (if the agency has an affiliation with or is under common control of a hospital providing such medical services). "Approved" means approved by the Council on Medical Education of the American Medical Association, or in the case of an osteopathic hospital, the Committee on Hospitals of the Bureau of Professional Education of the American Osteopathic Association, and, in the case of an intern or resident-in-training in the field of dentistry, approved by the Council on Dental Education of the American Dental Association.

**205.7 Outpatient Services.**—Outpatient services include any of the items or services described above which are provided under arrangements on an outpatient basis at a hospital, extended care facility, rehabilitation center, or outpatient department affiliated with a medical school, and (1) which require equip-



ment not readily available at the patient's place of residence or (2) which are furnished while he is at the facility to receive the services described in (1). The hospital, extended care facility, or outpatient department affiliated with a medical school must all be qualified providers of services. However, there are special provisions for the use of the facilities of rehabilitation centers (see § 200.3). The cost of transporting an individual to a facility cannot be reimbursed.

## **208. CONDITIONS FOR COVERAGE FOR HOME HEALTH SERVICES UNDER BOTH HOSPITAL AND MEDICAL INSURANCE**

**208.1 Patient Must Be Under Care Of A Physician.**—Items and services must be furnished to an individual who is under the care of a physician. This physician may be the patient's private physician; **or**, a physician on the staff of the home health agency; **or** a physician working under an arrangement with the institution which is the patient's residence; **or** if the agency is hospital-based, a physician on the hospital or agency staff. The attending physician establishes the plan of treatment and also certifies to the necessity for home health services.

**208.2 Services Must Be Furnished By Agency.**—Items and services must be furnished by a participating home health agency or by others under arrangements made by the agency. (See § 200.2 for definition of "under arrangements.")

**208.3 Services Must Be Furnished Under A Plan.**—Items and services must be furnished under a plan established and periodically reviewed by a physician and which relates the items and services to the patient's condition. A plan is "established" when it is reduced to writing by the physician and is made available to the home health agency which has accepted the patient as a client. The plan must specify the types of services required and should, as far as possible, provide a long-range forecast of likely changes in the patient's condition. It should include diagnosis, when and what nursing services are needed, drugs and medications to be used, diet, activity permitted, rehabilitation, therapy needed, medical social services needed, home health aide services needed, and supplies and appliances needed.

The plan must be signed by the attending physician and incorporated into the agency's permanent record for the patient. Any changes must be made in writing and signed by the physician or by a registered professional nurse on the staff of the agency pursuant to the physician's oral orders. All changes in orders for dangerous drugs and narcotics must be signed by the physician.

The plan must be reviewed by the attending physician, in consultation with agency professional personnel, at such intervals as the severity of the patient's

illness requires but at least every 2 months. Each review of a patient's plan should contain the initials of the physician and show the date performed. The agency's record need not be forwarded to the intermediary for review but will be retained in the agency's file.

When an individual has coverage under both Part A and Part B, home health plans under both parts should not operate concurrently. For example, a plan of treatment is established after hospitalization for a condition for which the patient was hospitalized, and the patient later requires home health services for a condition unrelated to the previous hospitalization but while the original plan of treatment is still in effect. The original plan of treatment should be modified to take into account the required home health services for the condition not related to previous hospitalization. Otherwise, there would be administrative difficulties in counting home health visits, particularly if two home health agencies become involved. Of course, if the patient does not have Part B coverage, the original plan of treatment cannot be modified to provide home health services not related to prior hospitalization.

When benefits under hospital insurance have been exhausted and a change to benefits under medical insurance is made, it is not necessary for the physician to change the plan of treatment.

**208.4 Services Furnished On a Visiting Basis.**—Items and services must be furnished on a visiting basis in the place of residence used as the individual's home. There must be a medical judgment that the patient must be confined for health reasons, and requires home health services on a part-time or intermittent visiting basis, even though the patient may be ambulatory to some extent and may on occasion be able to leave his place of residence with or without aid.

If the services cannot be provided at the patient's residence, because they require equipment which cannot be made available in the patient's home, they may be provided elsewhere (see § 200.2A3 and § 205.7).

## **210. SPECIAL CONDITIONS FOR COVERAGE OF HOME HEALTH SERVICES UNDER HOSPITAL INSURANCE**

In addition to the conditions listed in § 208, the following conditions must be met for coverage under hospital insurance.

**210.1 Time Limitation for Establishment of Plan.**—The plan for home health services must be established within 14 days after discharge from a hospital of which the beneficiary was an inpatient for at least 3 consecutive calendar days (a stay for a part of a day is considered to be a full day for this purpose), or, from a covered stay in a participating extended care facility (see § 112.2 for definition of extended care facility).



The discharge from the hospital which is required to qualify home health services for payment under hospital insurance must occur after June 30, 1966, and in a month in which the patient has attained age 65. Since the extended care facility discharge must be from a covered stay, it must occur after December 31, 1966.

There must be an actual discharge from a hospital or extended care facility. If, for example, a patient is discharged from an approved extended care facility to another section of the facility which he uses as his home, he may, if otherwise eligible, receive home health services. If, however, a nursing home approved as an extended care facility has no separate wing or building for use as a place of residence after discharge, the individual will be considered as still an inpatient of the extended care facility and consequently cannot receive home health services.

**210.2 Related Illness or Impairment.**—In order for home health services to be covered under hospital insurance, a doctor must certify that the patient needs intermittent nursing care or physical or speech therapy for any condition for which he was receiving inpatient hospital or extended care services.

**210.3 Transfer of Patient.**—If it becomes necessary for the patient to transfer to a different physician or home health agency (in a different locality) after the timely establishment of a physician's plan requirement was met, the original plan may be continued in the new locality if:

A. There is a referral by the patient's physician in the old locality of both the patient and the plan to a physician in the new locality.

B. The patient's physician in the new locality accepts the original plan of treatment and assumes the responsibility of conducting the required periodic reviews of the plan. The plan could be modified from time to time as determined necessary by the patient's physician in the new locality.

C. A participating home health agency in the new locality accepts the patient.

D. The number of posthospital home health visits already used in the old locality in the (applicable) year would be taken into account in determining when the limit of 100 visits under the hospital plan is reached.

**Example:** A health insurance beneficiary has received 40 home health visits under Part A when it is decided that his overall recovery would be hastened if he moved to a relative's home in a city 100 miles away. However, the physician who established and is reviewing his home health plan recommends that the physical therapy treatments he has been receiving be continued. A physician in the distant city concurs and agrees to take responsibility for continuance of the plan. When the patient moves, the plan is submitted to a home health agency in that city and services continue as before. The patient is entitled to the remaining 60 home

health visits in the applicable year under Part A at his new residence.

## **212. SPECIAL CONDITIONS FOR COVERAGE OF HOME HEALTH SERVICES UNDER SUPPLEMENTARY MEDICAL INSURANCE**

**212.1 Non-Eligibility under Hospital Insurance.**—For home health services to be covered under supplementary medical insurance, the patient must be currently enrolled in the medical insurance plan and where the home health services to be provided are covered under hospital insurance, not be eligible to receive such services under hospital insurance. Where a patient is eligible for home health services which are covered under both programs, the services are chargeable under hospital insurance. When the benefits payable under hospital insurance are exhausted, he may then utilize the benefits available under the supplementary medical insurance program. A plan covering services under the medical insurance program must be established by the physician, but it may be established at any time.

Prior inpatient care in a hospital or extended care facility is **not** required for coverage of home health services under the supplementary medical insurance plan.

**212.2 Change to Medical Insurance Home Health Services on Change of Residence.**—A patient who changes residence before exhausting his 100 home health visits under hospital insurance can receive further home health services **only** under the medical insurance program if there is no further eligibility for home health services under the hospital insurance plan. This might occur, for example, in the following situations:

A. The physician in the old locality does not refer the patient to a physician in the new locality or terminates the posthospital home health plan, or

B. There is no physician in the new locality who agrees to accept both the patient and the plan, e.g., the new physician wants to establish an entirely new plan.

For coverage under medical insurance in these circumstances, the new physician must establish a new plan.

See § 210.3 for conditions under which home health services under hospital insurance may continue in the new locality.

## **215. DURATION OF HOME HEALTH SERVICES**

Under **hospital insurance** the patient is entitled to up to 100 visits in the 1-year period following the **most recent discharge** from a 3-day hospital stay or, if later, in the 1-year period after a discharge from a covered stay in an extended care facility. It is impor-

tant to note that under hospital insurance, coverage extends to only that number of visits (100 or less) as are furnished after the beginning of one spell of illness and before the beginning of the next. Both the "stay" and "timely establishment of plan" requirements must be met in the new spell of illness to provide coverage for a new series of home health visits.

If an individual is released from a hospital and has a timely home health plan established, his subsequent return in the same spell of illness to a hospital for a period of 3 or more days or to a covered stay in a participating extended care facility, extends the 1-year period for his visits, dated from the most recent discharge. The total number of visits available before the next spell of illness begins remains unchanged.

The end of the year for hospital insurance purposes is determined as follows:

Count 365 days (366 when February 29 is included) beginning with the later of the following:

a. The date of discharge after June 30, 1966, from a 3-day stay in any hospital, or

b. The date of discharge after December 31, 1966, from an extended care facility stay for which post-hospital extended care benefits were payable on the patient's behalf.

Under **supplementary medical insurance** a patient is entitled to 100 visits in a calendar year. Entitlement to visits under supplementary medical insurance is related to the calendar year and is unaffected by the patient's spell(s) of illness. If entitled to services under both hospital insurance and supplementary medical insurance, the visits must first be charged against the hospital insurance.

The end of the year under medical insurance is December 31.

**Example 1.** Jones is hospitalized on February 10 and discharged on March 15, 1967; he has no other hospital or extended care facility stay in 1967, or 1968. He has 100 home health visits beginning the latter part of March and ending on February 20, 1968. All 100 visits are paid for **under hospital insurance** since the 1-year period runs from March 15, 1967, the date of the hospital discharge, to March 14, 1968. Although Jones' spell of illness ended on May 14, 1967, 60 days after the hospital discharge, home health eligibility was unaffected since a new spell of illness did not begin subsequently.

**Example 2.** Robinson was an inpatient in a hospital four times during the same spell of illness, i.e., there was no period of 60 consecutive days during which he was not hospitalized. He was discharged from the hospital, which meets the requirements to qualify subsequent home health services for payment under hospital insurance, on March 15, 1967, May 14, 1967, July 13, 1967, and September 12, 1967. Each hospital stay was for at least 3 consecutive days except

the last one. He had home health visits beginning with May 23, 1967, based on a plan established after his hospital discharge of May 14. The 1-year period for home health services **under hospital insurance** began May 14, 1967, the date of his most recent discharge (in relation to the first home health visit in the spell of illness) from a hospital after a stay of 3 days; it can end no later than July 13, 1968, 1 year after the latest discharge from a hospital stay of at least 3 consecutive days. Thus, in some situations, the "1-year period" during which an individual may have up to 100 home health visits may in fact exceed a year overall.

**Example 3.** Smith is hospitalized on February 10 and discharged on March 15. He reenters the hospital on July 4. He had 30 home health visits between March 15 and July 4. Since he had been out of the hospital for more than 60 days after his discharge on March 15, a new spell of illness began on July 4, when he reentered the hospital. Therefore, he is not entitled to any additional home health visits **under hospital insurance** based on his February-March hospital stay. However, an additional 100 home health visits under hospital insurance may begin based on his hospitalization beginning July 4, if he is confined for at least 3 days. If it is for less than 3 days, he will not qualify for home health visits under hospital insurance in the new spell of illness. However, if he is enrolled in the supplementary medical insurance program he is entitled to an additional 100 visits **under Part B** through December 31, subject to the deductible provisions.

**Example 4.** Brown is discharged from a hospital on February 15, 1967, after a 3-day stay. He begins receiving home health visits on February 18, 1967. He has until February 14, 1968, to use his 100 visits **under hospital insurance**. In July, however, he receives his 100th visit, exhausting the number of visits to which he is entitled under hospital insurance. Coverage of his home health visits may continue unbroken, if he is enrolled under supplementary medical insurance. In that event, he may receive an additional 100 visits **under medical insurance** through December. In January, 1968, he becomes entitled to an additional 100 visits under supplementary medical insurance for the calendar year of 1968.

## 218. COUNTING VISITS UNDER THE HOSPITAL AND MEDICAL PLANS

The number of visits are counted in the same manner under both the hospital plan and medical plan.

**218.1 Visit Defined.**—A visit is a personal contact in the place of residence of a patient made for the purpose of providing a covered service by a health worker on the staff of the home health agency or by others under contract or arrangement with the home health agency; or a visit by a patient on an outpatient basis to a hospital, extended care facility, or rehabilitation



center, or outpatient department affiliated with a medical school when arrangements have been made by the home health agency for one or more of the covered services. (See § 200.)

**218.2 Counting Visits.**—If a visit is made simultaneously by two or more persons from the home health agency to provide a **single** service, for which one person supervises or instructs the other, it is counted as **one visit**. (See example 1.) If **one** person visits the patient's home more than once during a day to provide services, **each** visit is recorded as a separate visit (see example 2). If a visit is made by two or more persons from the home health agency for the purpose of providing separate and distinct types of services, **each** is recorded—i.e., **two or more visits** (see example 3). If the patient is taken elsewhere for the service because the service could not be furnished in his residence, **one visit** is counted **for each service** he receives (see example 4).

**Example 1.** If an occupational therapist and an occupational therapy assistant visit the patient together to provide therapy and the therapist is there to supervise the assistant, **one** visit is counted.

**Example 2.** If a nurse visits the patient in the morning to dress a wound and later must return to replace a catheter, **two** visits are counted.

**Example 3.** If the therapist visits the patient for treatment in the morning and the patient is later visited by the assistant for additional treatment, **two** visits are counted.

**Example 4.** If an individual is taken to a hospital to receive outpatient therapy that could not be furnished in his own home (e.g., hydrotherapy) and, while at the hospital receives speech therapy and other services, **two or more** visits would be charged.

**Example 5.** Many home health agencies provide home health aide services on an hourly basis (ranging from 1 to 8 hours a day). However, in order to allocate visits properly against a patient's maximum allowable visits, home health aide services are to be counted in terms of visits. Thus, regardless of the number of continuous hours a home health aide spends in a patient's home on any given day, one "visit" is counted for each such day. If, in a rare situation, a home health aide visits a patient for an hour or two in the morning, and again for an hour or two in the afternoon, two visits are counted.

Under both hospital insurance and supplementary medical insurance, visits count toward the 100-visit maximums only if payment was made for the visits by the program or, if payment would be made if requested by the patient, and the certification requirements (see §§ 240ff.) were met. Visits by personnel other than those providing covered services are not counted. Salaries of personnel employed by the agency to assist in overall operation of the program (e.g., a nutritionist)

may be taken into consideration in computing overhead costs of the agency when claiming reimbursement.

**Important item to remember about visits under supplementary medical insurance:** visits provided a patient during the period in which he is incurring sufficient expenses to satisfy the deductible **will count** toward the 100-visit maximum, even though reimbursement is not possible because the \$50 deductible has not been satisfied.

## **220. DEDUCTIBLE AND COINSURANCE UNDER SUPPLEMENTARY MEDICAL INSURANCE**

**Note:** If the patient is receiving home health services under the **hospital insurance program**, he does not need to meet any deductible or coinsurance requirements. The home health agency will receive payment under the program for covered services based on the determined reasonable costs.

**220.1 Deductible.**—Where the patient is receiving services under the supplementary medical insurance program, a \$50 deductible requirement must first be met. Only expenses incurred by the use of covered services under supplementary medical insurance can be used to satisfy the deductible. **Exception:** The \$20 deductible applicable to each outpatient diagnostic study under hospital insurance may be used to help satisfy the \$50 deductible under supplementary medical insurance.

Expenses incurred in the last 3 months of the year which were applied toward the deductible in that year may also be applied toward the deductible in the following year. If the patient has already satisfied the deductible in the calendar year, this will be indicated on the Notice of Medical Insurance Utilization he receives from the Social Security Administration after a Part B home health services claim is processed, or on the Explanation of Benefits form he receives from the intermediary after other Part B claims are processed (see § 304). **The agency should attempt to ascertain whether or not the patient has satisfied the deductible before charging him for this amount.**

**220.2 Coinsurance.**—After sufficient expenses have been incurred to satisfy the deductible, the home health agency will be reimbursed by the program for 80 percent of the reasonable cost of covered services which it provided or for which it made arrangements. The patient is responsible for a coinsurance amount of 20 percent of the reasonable charges.

## **225. PROVIDER-BASED PHYSICIANS' SERVICES**

The medical insurance program covers charges for physicians' services rendered to individual beneficiaries. The charges of provider-based physicians (e.g.,



those having a contractual relationship with a provider) for services directed to the medical care of the individual patient must be specially billed. Reimbursement is made on a reasonable charge basis by the supplementary medical insurance (Part B) intermediary. (The services of interns and residents-in-training are reimbursed on a reasonable cost basis by the hospital insurance intermediary.) Thus the charges for physicians' services rendered individual beneficiaries are allocated to the medical insurance program and distinguished from provider services payable under either the hospital or medical insurance plan. Claims for such physicians' services rendered in connection with home health agency services will be made by the physician, if he accepts assignment from the patient, or by the patient directly, on Form SSA-1490, Request for Payment.

Provider-based physicians often perform services other than those clearly directed to the medical care of individual patients. These may involve teaching and administrative services, and services that benefit the home health agency's patients as a group. Such physician services, not directly related to an individual patient, must be considered in computing reimbursable agency costs and, as such, will be reflected in amounts payable to the agency for services rendered program beneficiaries.

### **230. SPECIFIC EXCLUSIONS FROM COVERAGE AS HOME HEALTH SERVICES**

In addition to the general exclusions from coverage under health insurance listed in § 232, the following are also excluded from coverage as home health services:

a. Services or items which would not be paid for if provided to an inpatient of a hospital, such as private duty nursing service, or items of comfort which are not necessary for treatment, e.g., television.

b. Meals-on-wheels or similar food service arrangements.

c. Domestic or housekeeping services which are unrelated to patient care.

d. Transportation services, e.g., from place of residence to a facility to receive home health services on an outpatient basis.

### **232. GENERAL EXCLUSIONS**

No payment may be made under **either** the hospital insurance plan or supplementary medical insurance plan for the following items and services:

**232.1 Items and services which are not reasonable and necessary** for the diagnosis or treatment of illness or injury or to improve the functioning of a malformed body member.

**232.2 Items and Services for Which There Is No Legal Obligation to Pay.**—This exclusion does not apply if the patient has a legal obligation to pay,

or some other person or organization has a legal obligation to pay for or provide the items or services. Thus, for example, the exclusion does not apply to care provided or paid for by a prepayment plan.

Free services are excluded from coverage, e.g., free chest X-rays provided by health organizations. In applying this exclusion the determining factor is that there is no legal obligation to pay for the items or services, and not merely the fact that the patient is not charged because of other considerations. This exclusion, therefore, does not prohibit program payment for services rendered to members of religious orders who are not charged because of a vow of poverty or to indigents who are not charged because of their inability to pay.

Covered services furnished to residents of a **home for the aged** are not excluded where payment is sought from the resident for maintenance and health services to the extent of his ability to pay. This would be the case, for example, where at the time of admission the resident assigns to the home any assets or income he may have. However, where all services are furnished by the home on a purely charitable basis (i.e., no payment is accepted from residents regardless of their ability to pay), payment could not be made under the health insurance program for items and services furnished by the home. In this situation, however, payment could be made for services furnished by a source independent of the home if that source customarily charges for such services. Thus, payment could be made for services furnished by an independent hospital to which a resident of the home is sent.

Certain union homes accept no payment from residents regardless of their ability to pay. Payment may, nevertheless, be made for services provided by such homes where admission to the home and access to the services is a matter of right for union members who meet the necessary qualifications.

Payment may also be made for services to a patient whose need for services resulted from the act or negligence of another who is or may be legally liable for the patient's medical expenses. The existence of a third person's liability does not affect the patient's obligation to pay for the services he receives.

**232.3 Items and services which are paid for by a governmental entity** other than under the Social Security Act or under a health benefits or insurance plan for employees of the governmental entity. The Secretary of Health, Education, and Welfare may specify other exceptions to this exclusion. The Secretary has approved payment for items and services (otherwise covered) even though provided free:

1. If furnished in qualified State or local government-operated hospitals, including psychiatric and tuberculosis hospitals, where the hospital is a general or special hospital serving the general community;

2. If paid for by a State or local governmental entity and furnished an individual as a means of control-

ling infectious diseases or because of the individual's medical indigence. These services need not be furnished in a hospital.

**232.4 Items and services which are not provided within the United States** (except for emergency inpatient hospital services furnished outside the United States under certain conditions and payment on behalf of railroad beneficiaries for covered hospital insurance services furnished in Canadian hospitals). The United States includes the 50 States, the District of Columbia, the Commonwealth of Puerto Rico, the Virgin Islands, Guam, and American Samoa.

**232.5 Items and services which are required as a result of war**, or of an act of war, occurring after the effective date of the patient's current coverage.

**232.6 Personal Comfort Items.**—These are items which do not contribute meaningfully to the treatment of an illness or injury or the functioning of a malformed body member. Charges for special items requested by the patient such as radio, television, telephone, and air conditioner, and beauty and barber services are excluded from coverage. Items such as heat lamp treatments and massages are covered only when ordered by a physician.

**232.7 Routine physical checkups, eyeglasses or eye examinations** for the purpose of prescribing, fitting, or changing eyeglasses, **hearing aids or related examinations**, or **immunizations**. Routine physical checkups include (a) examinations performed without relationship to treatment or diagnosis of a specific illness, symptom, complaint, or injury, and (b) examinations required by third parties such as insurance companies, business establishments, or Government agencies.

The exclusions apply to eyeglasses or contact lenses, and eye examinations solely for the purpose of prescribing, fitting, or changing eyeglasses or contact lenses for refractive errors. The exclusions do not apply to examinations performed in conjunction with an eye disease such as glaucoma or cataracts, or to post-surgical eyeglasses which are customarily used during convalescence from eye surgery, or to prosthetic lenses required by the aphakic patient. In the last situation, the prosthetic lens is a replacement for an internal body organ—the lens of the eye.

Vaccinations or inoculations are excluded as “immunizations” unless they are directly related to the treatment of an injury or direct exposure such as anti-rabies treatment, tetanus antitoxin or booster vaccine, botulin antitoxin, antivenin sera, or immune globulin.

**232.8 Orthopedic Shoes or Other Supportive Devices for the Feet.**—The exclusion of orthopedic shoes does not apply to such a shoe if it is an integral part of a leg brace.

**232.9 Custodial Care.**—The custodial care exclusion precludes payment for patient care which primarily requires protective services rather than definitive medical and skilled nursing care.

**232.10 Cosmetic Surgery or Expenses Incurred in Connection With Such Surgery.**—Cosmetic surgery includes any surgical procedure directed at improving appearance, except when required for the prompt (as soon as medically feasible) repair of accidental injury or for the improvement of the functioning of a malformed body member. For example, this exclusion does not apply to surgery in connection with treatment of severe burns or repair of the face following a serious automobile accident or surgery for therapeutic purposes, which coincidentally also serves some cosmetic purpose.

**232.11 Charges Imposed by Immediate Relatives of the Patient or Members of His Household.**

**232.12 Items and services in connection with the care, treatment, filling, removal, or replacement of teeth** or structures directly supporting the teeth. Payment may be made, however, for (a) surgery related to the jaw or any structure contiguous to the jaw, or (b) the reduction of any fracture of the jaw or any facial bone, including dental splints or other appliances used for this purpose.

**232.13 Items and services** to the extent that payment has been made, or can reasonably be expected to be made for **items or services under a workmen's compensation law** or plan of the United States or a State. Payments made for items and services under the health insurance program are subject to repayment to the appropriate trust fund if notice or information is received that payment has been made for the items and services under a workmen's compensation plan (see §§ 250 ff.).

**232.14 Items and services which the provider is obligated** by a law of or because of a contract with the Federal Government **to render at public expense**.

**232.15 Items and services furnished by a Federal provider of services** or other Federal agency except (a) for emergency inpatient hospital services and emergency outpatient hospital diagnostic services furnished by a Federal hospital meeting certain requirements; or (b) when the Federal provider of services has been determined by the Secretary of Health, Education, and Welfare to be providing services to the public generally as a community institution or agency.

## **235. PATIENT'S REQUEST FOR PAYMENT**

Before payment can be made for home health services, a written request for payment signed by the patient or by another person qualified to do so on his



behalf must be filed. For convenience, the request for payment has been made a part of the billing form.

**235.1 Execution of the Request For Payment.**—If at all practicable, the request should be signed by the beneficiary.

In certain circumstances, it would be impracticable for an individual to sign the request for payment himself if, when he begins home health services, he is incompetent, or otherwise in such a condition that he should not be asked to transact any business. In this situation, his representative payee (i.e., a person designated by the Social Security Administration to receive monthly benefits on the patient's behalf), a relative, legal guardian, or a representative of an institution usually responsible for his care, or a representative of a government entity providing welfare assistance should, if present at the time services begin be asked and permitted to sign on his behalf.

When no request for payment is obtained at the time of start of services, the home health agency should attempt to obtain such a request later, if possible, from the patient or other person as described above who may be at the patient's home. If this is not practicable, when the agency would ordinarily submit its bill to the intermediary, an authorized official of the agency may sign the request on his behalf.

When someone other than the patient signs the request for payment, the signer will submit a brief statement explaining his relationship to the patient and the circumstances which made it impracticable for the patient to sign, and the agency will forward the statement with its billing. The intermediary will generally accept such a statement as representing the true facts of the case in the absence of evidence to the contrary.

The agency should not routinely sign the request on behalf of any patient. If experience reveals an unusual frequency of such agency-signed requests from a particular agency, the matter will be subject to review by the intermediary.

If a fully competent and capable patient **refuses** to sign the request for payment necessary for the agency to obtain reimbursement for the services it furnished, the agency may charge the patient or other person for covered services.

**235.2 Filing of the Request For Payment.**—The request for payment must be filed with the intermediary, or with the Social Security Administration where the agency deals directly with the Government. It is desirable to have the request signed at the start of care; the request must be filed prior to or in connection with the first billing for services. Home health services for the purposes of requests for payment will be considered continuous and will, except as indicated below, require only a single request for payment.

A subsequent signed request for payment will be required if:

a. There is an interruption of 60 days or more in home health visits furnished by the same agency or

b. There is a transfer of the patient's care from one home health agency to another.

## **240. CERTIFICATION AND RECERTIFICATION BY PHYSICIANS**

**240.1 Content of the Physician's Certification.**—Under both the hospital insurance and the supplementary medical insurance programs, no payment can be made for covered home health services unless a physician certifies that:

a. the home health services are or were required because the individual is or was confined to his home (except when receiving outpatient services);

b. the individual needed skilled nursing care on an intermittent basis or needed physical or speech therapy;

c. a plan for furnishing such services to the individual has been established and is periodically reviewed by a physician; and,

d. the services are or were furnished while the individual was under the care of a physician.

In addition, for services received under hospital insurance, the physician must also certify that services were needed to treat any of the conditions for which the beneficiary received inpatient hospital or post-hospital extended care services during the related hospital or extended care facility stay. Where services are provided under supplementary medical insurance, it is not necessary to relate the need for these services to a period of prior hospitalization or a stay in an extended care facility.

Since the certification is closely associated with the plan of treatment, the same physician who establishes the plan must also certify to the necessity for home health services. Certifications must be obtained at the time the plan of treatment is established or as soon thereafter as possible.

**240.2 Method and Disposition of Certifications.**—There is no requirement that the certification, or recertification discussed below, be entered on any specific form or handled in any specific way, as long as the intermediary can determine, where necessary, that the certification and recertification requirements are met. The certification by the physician will be retained by the home health agency, but the agency must certify on the billing form that the requisite certification and recertifications have been made by the physician and are on file in the agency when it forwards the request for reimbursement to the intermediary.

**240.3 Recertification.**—Under both the hospital insurance and supplementary medical insurance programs, when services are continued for a period of time, the physician must recertify at intervals of at least once every 2 months that there is a continuing need for services and should estimate how long services will be



needed. The recertification should be obtained at the time the plan of treatment is reviewed since the same interval (at least once every two months) is required for the review of the plan. Recertifications must be signed by the physician who reviews the plan of treatment. The form of the recertification and the manner of obtaining timely recertifications is up to the individual agency.

**240.4 Delayed Certification.**—The home health agency should obtain certifications and recertifications as promptly as possible. Payment will not be made unless the necessary certifications have been secured. In addition to complying with the usual content requirements, delayed certifications and recertifications must include an explanation for the delay and any other evidence the agency considers necessary in the case. The format of delayed certifications and recertifications and the method by which they are obtained, will be left to the agency.

## **245. REFUNDS**

In its participation agreement the home health agency agrees not to charge for items or services for which an individual is entitled to have payment made on his behalf. Thus, when the patient's eligibility is verified, the agency in order to have payment made under health insurance, is obliged to refund to the proper party any payments previously collected from beneficiaries, other insurance carriers, welfare, or others for covered services, except for deductibles, coinsurance amounts, and noncovered charges. When payment is made under medical insurance and the intermediary is aware that the beneficiary previously paid part of the reimbursable medical insurance expenses, the intermediary will deduct that part from the home health agency reimbursement and will refund the amount to the beneficiary.

## **250. WORKMEN'S COMPENSATION**

Payment is excluded for any items or services to the extent that payment has been made, or can reasonably be expected to be made under a workmen's compensation law or plan of the United States or a State. Health insurance payment for items or services is conditioned on reimbursement to the hospital or supplementary medical insurance trust fund when notice or other information is received that payment for them has been made under workmen's compensation.

**250.1 Effect of Workmen's Compensation Payments on Spell of Illness.**—An individual's spell of illness will begin with the first day he receives inpatient services from a qualified hospital or extended care facility even though workmen's compensation coverage, rather than the health insurance program, pays for these services, if he is entitled to hospital insurance benefits in that month.

**250.2 General Procedures in Workmen's Compensation Cases.**—When the home health agency is told that the patient's illness or injury is employment-related, this will be indicated on the billing form, and the employer's name and address given.

If the agency knows that a workmen's compensation payment has already been made for the current illness or injury (e.g., for prior hospitalization) it should furnish the intermediary whatever information is available with the start of care notice, since it is possible that subsequent care for the same injury or disease will also be compensable under workmen's compensation. If there is a possibility of workmen's compensation coverage for home health care, the agency should file its claim with the workmen's compensation carrier.

Even though workmen's compensation payment has been or probably will be made, the agency should submit its bill for covered health insurance services in the usual manner to the intermediary, or to the Social Security Administration if the agency is dealing directly with the Government.

a. If the agency has received a workmen's compensation payment, the intermediary will deduct the amount of that payment which was for covered health insurance services from the agency's bill. The agency will be notified by the intermediary of the extent to which its bill was covered by workmen's compensation. The patient will also be notified of this action.

b. If there is a reasonable likelihood that the agency will be paid by workmen's compensation for the patient's care the intermediary will notify the agency that health insurance payments are precluded because of the expected workmen's compensation payment. The patient is also notified of this decision.

If workmen's compensation does not pay or pays only in part for covered services, the agency may reopen the question of its bill with the intermediary.

c. If the intermediary determines that workmen's compensation payments cannot reasonably be expected, it will pay the agency for covered health insurance services on condition that the payment will be refunded if workmen's compensation later pays for the services. No conditional payment will be made unless workmen's compensation payment is doubtful (e.g., where the employer is contesting his liability under workmen's compensation or his liability for the expenses in question).

## **255. HOME HEALTH AGENCY PROTEST OF PAYMENT DETERMINATION**

The home health agency and its intermediary should attempt to resolve mutually any differences involving payment for services that arise from the application of the cost formula or the amount payable in a specific case. While no appeal is available for home health agencies or other providers from intermediary determinations involving payments, provider complaints and protests will be considered in Social Security Adminis-

tration review of the intermediary's application of the cost formula or its compliance with the other terms of its agreement with the Government.

## **257. BENEFICIARY PROTESTS AND APPEALS OF PAYMENT DETERMINATIONS**

**A. Hospital Insurance Program.**—An individual dissatisfied with any determination of the amount of benefits payable on his behalf under hospital insurance may have his claim reconsidered by the Social Security Administration. If he is not satisfied with the reconsideration determination and the amount in controversy is \$100 or more, he may request a hearing by the Social Security Administration. If the amount in controversy is \$1,000 or more and he is dissatisfied with the hearing decision, the individual may initiate action for Federal court review of the claim.

**B. Medical Insurance Program.**—An individual dissatisfied with denial of a request for payment of medical insurance benefits, or with the amount of medical insurance benefits paid, or with the promptness with which his request for payment is acted upon is entitled to an opportunity for a review by, and if still dissatis-

fied, to a fair hearing by the medical insurance intermediary. Since the home health agency is paid for the medical insurance services it furnishes by the same intermediary that makes hospital insurance payments to the home health agency, this intermediary is responsible for the review and hearing under medical insurance.

A patient dissatisfied with a payment for the services of a provider-based physician is entitled to a review by and, if still dissatisfied, to a fair hearing by the medical insurance intermediary to whom the bill for the physician's services was submitted for payment.

**C. Patient protests** concerning entitlement to health insurance benefits, or the denial, amount, or promptness of payment for items or services furnished by the home health agency under hospital or medical insurance should be handled, if simply amenable to explanation or correction, by the home health agency. If he is still dissatisfied, the patient should be referred to his social security district office. The district office can offer assistance to the beneficiary in determining his appeal rights and can answer specific questions about the appeal procedures. The district office can also assist the individual in completing the necessary forms for requesting reconsideration or hearing.

## CHAPTER III

### START OF CARE PROCEDURES

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## CHAPTER III

### START OF CARE PROCEDURES

#### 300. SUMMARY OF START OF CARE PROCEDURES

The purpose of this section is to give a brief outline of routine handling of admissions. Detailed instructions on procedures as well as descriptions of special situations are given in subsequent sections.

The first step in preparing the start of care notice for home health services is to ask the patient for his health insurance card. **It is very important that the claim number on this card be accurately recorded on the start of care notice since the case cannot be processed if the number is missing or incorrect.**

If you cannot obtain the health insurance claim number from the patient, you should get in touch with the Social Security Administration district office for help in securing a claim number for the patient.

The second step is to record information about the patient's prior hospital or extended care facility stays, or any prior home health services furnished, and the date the present home health plan was established. This information will help the intermediary to determine the patient's eligibility. Your intermediary (or the Social Security Administration, if you are dealing directly with the Government) will make any necessary verification of prior stays.

The third step is to fill in the other items on the start of care notice, have the patient sign the form, and send the information to your intermediary, or the social security district office if you deal directly.

Your intermediary will check the Social Security Administration central record, verify a prior stay if necessary, then send you a reply which will show whether the patient is eligible under hospital or medical insurance, the number of visits remaining, and deductible status. With this information you will be able to prepare your billing form. (If the visits are to be charged to medical insurance, care will have to be exercised in collecting the \$50 deductible or any part of it.)

#### 302. HEALTH INSURANCE CARD

The Social Security Administration maintains in Baltimore, Maryland, the records of all persons entitled to health insurance. After entitlement is established each beneficiary is issued a health insurance card by

the central office of the Social Security Administration (or in some cases by the Railroad Retirement Board) for use in obtaining hospital insurance benefits, medical insurance benefits, or both. The health insurance claim number on the card is essential in locating the patient's record when a claim for benefit payment is made. **No start of care notice or billing form should be forwarded without the correct claim number.** Exhibit 1 of this chapter shows the health insurance cards and briefly explains the numbering system as an aid in recognizing valid numbers.

The home health agency should ask each patient who gives his age as 65 or older for his health insurance card to determine his health insurance entitlement status and obtain the correct health insurance claim number. If a patient is within three months of age 65 and has not yet applied for health insurance entitlement, it will be helpful if he, or someone on his behalf, is advised to contact the social security district office. The home health agency may wish to arrange with the district office to bring such cases routinely to the attention of the district office.

A health insurance card is acceptable without a signature. However, the patient should be asked to sign the card if he has not already done so.

#### 304. NOTICE OF HOSPITAL (OR MEDICAL) INSURANCE UTILIZATION OR EXPLANATION OF BENEFITS

If the patient cannot furnish his health insurance card, he may have a health insurance utilization form which shows his claim number. Form SSA-1533, Notice of Hospital Insurance Utilization (see Exhibit 2) is mailed to a beneficiary from the Social Security Administration in Baltimore shortly after **Part A** inpatient hospital, extended care, or **home health** benefits have been paid on his behalf. Form SSA-1533A, Notice of Medical Insurance Utilization (see Exhibit 3), is mailed to a beneficiary by SSA after payment of **Part B home health** benefits. An Explanation of Benefits is sent to a beneficiary by the Part B intermediary after payment of a supplementary medical insurance claim. The Part A intermediary sends the beneficiary a utilization notice after payment on his behalf for Part A or Part B outpatient hospital services. These forms, if current, may indicate to the home

health agency the patient's remaining eligibility under hospital or medical insurance, recent hospitalization, or deductible status under medical insurance. **However, a start of care notice must always be sent when home health services start regardless of the currency of any of these forms.**

### **306. CONTACTS WITH THE SSA DISTRICT OFFICE TO OBTAIN HEALTH INSURANCE CLAIM NUMBERS**

When a patient cannot furnish the health insurance claim number, it will be requested from the SSA district office. Ordinarily, the social security district office will have arranged with the home health agency for handling these requests. If it has not, the home health agency should get in touch with the nearest SSA district office to make such arrangements. Apart from assisting in determining correct claim numbers, the district office can help a beneficiary to replace a lost health insurance card.

**306.1 Information Required by SSA District Office.**—If the patient's social security account number is available, the district office will usually require no additional information to locate the claim number or determine that the patient has not established health insurance entitlement.

If the patient has ever been employed or self-employed, or sought employment, or filed Federal Income Tax returns, he should have a social security card. This card contains his social security account number which consists of 9 digits, 000-00-0000, but does not have the letter prefix or suffix which distinguishes the health insurance claim number. (See Exhibit 1.)

A social security account number is **not** sufficient for processing a claim.

If the account number is not available, the following information should be furnished.

a. The patient's name and statement as to whether or not he ever applied for social security monthly benefits, railroad retirement benefits, or for hospital insurance benefits;

b. If the patient says he applied, the name of the person on whose social security account the application was based, e.g., his own account or the account of a husband or a wife;

c. The patient's father's full name, mother's maiden name, and the patient's date and place of birth;

d. Patient's address.

If the home health agency cannot give all the identifying information required from the beneficiary, it should furnish as much as it has to the SSA district office.

**306.2 The SSA District Office Reply.**—The SSA district office will furnish the health insurance claim number as soon as possible. If the claim number is

not available, it will inform the home health agency of the action it is taking.

If an application for health insurance benefits is taken as a result of the request to the district office for a claim number or is pending when the home health agency requests a claim number, the district office will inform the agency when processing is completed. It will give the agency the claim number if the patient is entitled. The agency may then send the start of care notice information to the intermediary (or to the district office if the hospital deals directly with SSA).

### **310. START OF CARE NOTICE**

When a patient 65 years or older begins home health services, the home health agency will complete the start of care notice part (items 1-16) of Form SSA-1487, Home Health Agency Report And Billing Form. When signed, this represents the patient's request for payment of benefits. See §§ 235 ff.

When these items are completed, furnish the start of care information to the intermediary (or to the appropriate Social Security Administration district office if the agency deals with SSA). This information may be forwarded by mail, messenger, or telephone depending on prior arrangements made with the intermediary or the SSA district office. The bottom two copies of Form SSA-1487 can be sent to the intermediary as the start of care notice if the arrangement so provides. If some other means of transmitting start of care information to the intermediary is used, these copies of the form may be discarded.

**310.1 Completing Home Health Agency Start Of Care Notice, Form SSA-1487.**—Use a typewriter for all entries on the form, and show month, day, and year in six-digit numbers, e.g., 07/01/66. (See Exhibit 4 for a sample of the start of care notice.)

**Item 1. Patient's Name.** Enter the patient's name. It should be the same as that shown on his health insurance card, with the last name first. The master computer record is kept under this name. It is important to use the same name on the form even though the beneficiary may have changed his name.

**Item 2. Health Insurance Claim Number.** Enter the patient's health insurance claim number shown on his health insurance card, utilization notice, or as reported by the social security district office.

**Item 3. Patient's Address.** Enter the patient's mailing address.

**Item 4. Date of Birth.** Enter the patient's date of birth.

**Item 5. Sex.** Enter "X" in the appropriate block.

**Items 6 and 7. Home Health Agency Identification.** Enter the name and address of the agency and the agency's assigned health insurance provider number. This information may be preprinted on all copies of the agency's supply of these forms.



**Item 8. Medical Record No.** Enter the patient's medical record number if one is assigned by the agency and the number is needed for association of files and referral by the agency.

**Item 9. Attending Physician.** Enter the name and address of the attending physician. The name should be that of the physician who established the plan and will certify and recertify the medical necessity of the home health visits.

**Item 10. Date Care Started.** Enter the date on which home health services began.

**Items 11 and 12. Name and Address of Institution, If Any, Caring For Condition Later Requiring Home Health Services and Verified Dates of Stay.** In order for home health visits to be paid for on a posthospital (Part A) basis, the physician's plan for treatment of the condition must be established within 14 days after the patient's discharge from a hospital after a stay ~~on parts of~~ at least 3 consecutive days, or from a covered stay in an extended care facility. (Since payments for an extended care facility stay cannot be made until January 1, 1967, a date of discharge from an extended care facility stay prior to that date cannot be used to qualify a plan under Part A.) In item 11, enter the name and address of the hospital or extended care facility in all cases where it is applicable. However, enter the dates of stay in item 12 only when they are taken from official records.

Under certain conditions, payment continues under the original posthospital plan even though the patient is institutionalized again or transfers to another home health agency. If the patient had received home health services prior to his most recent stay in a hospital or extended care facility and posthospital visits are being resumed under the original plan, show the name and address of the agency furnishing the previous visits in item 11 and the inclusive days of service, if verified, in item 12. If the patient received posthospital home health services from another agency and transfers to your agency for visits under the original plan, and the date of the first visit by your agency is within a year after the date of discharge from the institution which qualified the patient for posthospital visits, enter the name and address of the other agency in item 11 and the inclusive dates of service, if verified, in item 12.

**Item 13. Date Home Health Plan Established.** Show the date on which the patient's attending physician established the plan for home health services.

**Item 14. Payment Source for Charges to Patient.** Check the appropriate block to indicate how the charges not reimbursed by hospital or medical insurance will be paid. Where a public agency will pay any part of the patient's charges, give the name and address of the agency and the patient's case number, if available.

**Item 15. Patient's Certification and Payment Request.** Have the patient or his authorized representative read and sign this statement before the bill is submitted for payment.

If the patient cannot sign his name because of his physical or mental condition, another person may sign on his behalf, e.g., John J. Jones by Jack A. Smith. In certain situations, a home health agency representative may sign on behalf of the patient. (See § 235.1 for who may file a payment request.)

Briefly explain the reason why the patient did not sign the form himself and show the relationship of the signer to the patient.

The statement should be read to the patient who signs by mark. The signature by mark should be witnessed by a person who knows the patient. Enter the name and address of any person witnessing the signature by mark.

**Item 16. Diagnosis.** Enter all diagnoses as furnished by the attending physician. List the primary condition first. Enter an "X" in the check box to indicate whether or not the condition was employment related. If the condition is known to be employment related, show the name and address of the employer. (See § 250.1 for effects of workmen's compensation involvement.)

### 315. CONTENTS OF INTERMEDIARY REPLY TO START OF CARE NOTICE

The reply to the start of care notice will be furnished by the intermediary to the agency according to prior arrangements. (If the agency deals directly with the Social Security Administration, it will receive a form reply to the start of care notice from the Bureau of Health Insurance, Direct Reimbursement.) The contents of the reply will be based on the intermediary's query of the SSA central record for eligibility information, and any necessary investigation of prior inpatient hospital or extended care facility stays or home health services.

The "Report of Eligibility" part of the home health agency report and billing form (see Exhibit 4) may be used as a reply to the start of care notice, where it is received by the intermediary as part of the start of care notice from the agency. Whether the reply will be given by telephone, mail, or wire to the agency, it will contain eligibility information similar to the content of the "Report of Eligibility." An explanation of the eligibility information in the "Report of Eligibility" is outlined below:

**A. Effective Date—Hospital Insurance.**—The month, day, and year of the patient's entitlement to hospital insurance benefits (Part A) will be shown. If not entitled, the entry will so indicate.

**B. Effective Date—Medical Insurance.**—This will show the month, day, and year of the patient's entitlement to medical insurance (Part B). The entry

will so indicate if the patient is not entitled to Part B benefits.

**C. Date of Start of Care.**—This date will be the one furnished by the agency in the start of care notice.

**D. Hospital Insurance Visits Available.**—This will show the remaining number of visits which may be reimbursed under Part A, based on the SSA central record and the information available to the intermediary.

**E. Supplementary Medical Insurance Visits Available.**—This will show the potential remaining home health visits which may be reimbursed under Part B.

**F. Last Discharge Date.**—The last discharge from an inpatient hospital or covered extended care facility stay will be shown.

**G. Medical Plan Deductible.**—This will show if the \$50 deductible is “met” or “not met,” but if not met will not indicate how much remains to be met. If the reply shows “not met,” the home health agency should ask the patient whether he has had other expenses that have been or could be applied toward the deductible (see § 220.1). The intermediary must requery the SSA central record when it receives the bill for payment from the home health agency in order to learn the amount of the deductible remaining to be met.

**H. Outpatient Psychiatric Expense.**—Whether the \$500 limitation has been “met” or “not met” will be shown in this item. If not met, the amount remaining to be met will not be shown. This item is informational only. The limitation applies only to expenses incurred for physicians’ services.

**I. Remarks.**—Any necessary explanation of eligibility information will be shown. This will include corrections in the name or health insurance claim number reported by the agency. When changes of this sort are reported, the name and claim number information on the billing form should be changed to reflect the correct name or health insurance claim number.

If the name and claim number information were not matched, the intermediary will request the home health agency to check its record, or to contact the patient or the nearest district office to obtain a valid claim number.

The agency may also be requested to verify reports of death shown in the patient’s SSA central record.

**J. Open Item.**—The information in this block will be completed by the intermediary when verifying reports of open items (open items are admissions or care-starts which are recorded in SSA central records, but are not yet closed out by the processing of a bill).

Where there is an open item reported from SSA central records to the intermediary or the Bureau of Health Insurance, Direct Reimbursement, either the intermediary or the SSA district office will contact the “open item” provider to verify the stay, the date of the prior discharge, and the status of the bill. The intermediary, or the Bureau of Health Insurance, Direct Reimbursement, will use this information to determine whether Part A benefits are payable and to compute the number of visits remaining under Part A and Part B.

### 320. RETROACTIVE ENTITLEMENT

When an application for social security benefits is filed by an individual 65 years of age or older, he may inform the social security district office that he had received home health services at some time during the 12-month retroactive period for which he may be entitled to hospital insurance benefits. This situation should arise very infrequently. It is not applicable to medical insurance visits, since medical insurance coverage cannot begin prior to the month of enrollment.

The Social Security Administration certificate of award to the patient will contain a notice informing him to get in touch with the provider who furnished him with past services. In these cases, follow the start of care procedures to obtain a report of eligibility from your intermediary before billing.

### 399. EXHIBITS

**Exhibit 1.** Health Insurance Cards and Claim Numbers.



**Exhibit 2.** Notice of Hospital Insurance Utilization (Form SSA-1533).

**Exhibit 3.** Notice of Medical Insurance Utilization (Form SSA-1533A).



**Exhibit 4.** Home Health Agency Report and Billing (Admission Copy)—Form SSA-1487.



## HEALTH INSURANCE CARDS

Health  Insurance	
SOCIAL SECURITY ACT	
NAME OF BENEFICIARY <b>JANE Q. DOE</b>	
CLAIM NUMBER <b>000-00-0000B</b>	SEX <b>FEMALE</b>
IS ENTITLED TO <b>HOSPITAL INSURANCE</b> 7-1-66 <b>MEDICAL INSURANCE</b> 7-1-66	
SIGN HERE 	

Front

Health  Insurance	
RAILROAD RETIREMENT BOARD	
NAME OF BENEFICIARY <b>JOHN C. DOE</b>	
CLAIM NUMBER <b>A-000-00-0000</b>	SEX <b>MALE</b>
IS ENTITLED TO <b>HOSPITAL INSURANCE</b> 7-1-66 <b>MEDICAL INSURANCE</b> 7-1-66	
SIGN HERE 	

Front

1. Carry your card with you when you are away from home.
2. Let your hospital or doctor see your card when you require hospital, medical or health services under "Medicare."
3. Get in touch with your social security office if you have questions about your rights under "Medicare."
4. Your card is good wherever you live in the United States.

WARNING: Issued for the sole use of the holder designated hereon. Intentional misuse of this card is unlawful and will make the offender liable to penalty.

PROPERTY OF UNITED STATES GOVERNMENT.  
IF FOUND DROP IN NEAREST U.S. MAIL BOX.

Return To: SOCIAL SECURITY ADMINISTRATION  
Baltimore, Maryland 21235

FORM SSA-1966 (7-66)

Back

1. Carry your card with you when you are away from home.
2. Let your hospital or doctor see your card when you require hospital, medical or health services under "Medicare."
3. Get in touch with your Railroad Retirement Board office if you have questions about your rights under "Medicare."
4. Your card is good wherever you live in the United States. For benefits in Canada, write to the Railroad Retirement Board.

WARNING: Issued for the sole use of the holder designated hereon. Intentional misuse of this card is unlawful and will make the offender liable to penalty.

PROPERTY OF UNITED STATES GOVERNMENT.  
IF FOUND DROP IN NEAREST U.S. MAIL BOX.

Return to: RAILROAD RETIREMENT BOARD  
844 Rush Street, Chicago, Illinois 60611

Form G-43 (2-66)

Back

## HEALTH INSURANCE CLAIM NUMBERS

Most HI claim numbers are 9 digits with a letter or letter and numeral suffix; e.g., 000-00-0000B or B1. They may also be 6-or-9-digit numbers with lettered prefixes; e.g., A000000, A-000-00-0000; or WD-000000, WD-000-00-0000. Numbers with one or more letter prefixes identify Railroad Retirement Board annuitants.

Possible suffixes are:

A, B, B1, B2, B3, B4, B5, B6, or B9.

C1, C2, C3, C4, or C5 (Suffixes higher than "5" are possible, but unlikely)

D, D1, D2, D3, D4, D5, D6, or D7

E, E1, E2, or E3

F1, F2, F3, F4, F5, F6, F7, or F8

HB, HB1, HB2, HB3, HB4, HB5, HB6, or HB9

HC1, HC2, HC3, HC4, or HC5

M, M1, and T (Suffix letter "T" indicates entitlement to hospital or hospital and medical insurance; letters M and M1 indicate that the patient is eligible for supplementary medical insurance benefits but not for hospital insurance benefits.)





# EXHIBIT 2

Notice of Hospital Insurance Utilization, SSA-1533

FORM SSA-1533 (5-66)



## DEPARTMENT OF HEALTH, EDUCATION, AND WELFARE SOCIAL SECURITY ADMINISTRATION BALTIMORE, MARYLAND 21235

### NOTICE OF HOSPITAL INSURANCE UTILIZATION

NAME AND ADDRESS OF THE BENEFICIARY  
OR REPRESENTATIVE OF THE BENEFICIARY

DATE:  
HEALTH INSURANCE CLAIM NUMBER:

The bill for HOSPITAL INSURANCE services described below was recently submitted under your health insurance claim number and recorded to your account.

TYPE OF SERVICES	DATES COVERED BY BILL		NUMBER OF HOME HEALTH VISITS INCLUDED
	FROM	TO	

Institution or agency  
providing services

Office which handled  
your claim

For each spell of illness, your HOSPITAL INSURANCE under Medicare pays for the costs of all covered services, with certain exceptions. These are the exceptions for this bill:

### RECORD OF ADDITIONAL BENEFITS AVAILABLE

As of the date of this notice, your record of inpatient hospital and extended care benefits for the spell of illness involved and home health benefits is as follows:

INPATIENT HOSPITAL DAYS			EXTENDED CARE FACILITY DAYS			HOME HEALTH VISITS		
USED THIS BILL	USED TO DATE	REMAINING	USED THIS BILL	USED TO DATE	REMAINING	USED THIS BILL	USED TO DATE	REMAINING

If you have to use HOSPITAL INSURANCE services again, please take this latest notice with you and show it, along with your Health Insurance card, to the agency or institution furnishing the services.

*Robert M. Ball*  
Robert M. Ball  
Commissioner of Social Security

PLEASE READ THE OTHER SIDE OF THIS NOTICE FOR IMPORTANT INFORMATION.





## EXHIBIT 3

Notice of Medical Insurance Utilization, SSA-1533A

FORM SSA-1533A (5-66)



DEPARTMENT OF  
HEALTH, EDUCATION, AND WELFARE  
SOCIAL SECURITY ADMINISTRATION  
BALTIMORE, MARYLAND 21235

## NOTICE OF MEDICAL INSURANCE UTILIZATION

NAME AND ADDRESS OF THE BENEFICIARY  
OR REPRESENTATIVE OF THE BENEFICIARY

DATE:

HEALTH INSURANCE CLAIM NUMBER:

The bill for MEDICAL INSURANCE services described below was recently submitted under your health insurance claim number and recorded to your account.

TYPE OF SERVICES	DATES COVERED BY BILL		NUMBER OF HOME HEALTH VISITS INCLUDED
	FROM	TO	

Institution or agency  
furnishing services

Office which handled  
your claim

Each year, as soon as your covered medical expenses go over \$50, your MEDICAL INSURANCE will pay 80 percent of the reasonable costs or charges for all additional covered services for the rest of the year. The computation of MEDICAL INSURANCE benefits for this bill is shown below.

TOTAL COVERED CHARGES	AMOUNT TOWARD \$50 DEDUCTIBLE	20% PAYABLE BY BENEFICIARY	TOTAL PAYABLE BY BENEFICIARY

## STATUS OF MEDICAL INSURANCE RECORD

As of the date of this notice, the status of your MEDICAL INSURANCE record is as follows:

*Robert M. Ball*  
Robert M. Ball  
Commissioner of Social Security

PLEASE READ THE OTHER SIDE OF THIS NOTICE FOR IMPORTANT INFORMATION.



# EXHIBIT 4

## Home Health Agency Report And Billing, SSA-1487 (Admission Copy)

<small>DEPARTMENT OF HEALTH, EDUCATION, AND WELFARE SOCIAL SECURITY ADMINISTRATION</small> <b>HOME HEALTH AGENCY REPORT AND BILLING</b>			Form Approved. Budget Bureau No. 72-R736		
1. PATIENT'S LAST NAME		FIRST NAME	MI	2. HEALTH INSURANCE CLAIM NUMBER	
3. PATIENT'S ADDRESS (Street number, City, State, Zip Code)				4. DATE OF BIRTH	5. SEX <input type="checkbox"/> M <input type="checkbox"/> F
6. HOME HEALTH AGENCY NAME AND ADDRESS		7. PROVIDER NO.	9. NAME AND ADDRESS OF ATTENDING PHYSICIAN		
		8. MEDICAL RECORD NO.			
10. DATE CARE STARTED	11. NAME AND ADDRESS OF INSTITUTION, IF ANY, CARING FOR CONDI- TION LATER REQUIRING HOME HEALTH SERVICES			12. VERIFIED DATES OF STAY IN ITEM 11 FROM TO	13. DATE HOME HEALTH PLAN ESTABLISHED
14. PAYMENT SOURCE FOR CHARGES TO PATIENT A. <input type="checkbox"/> SELF OR FAMILY    C. <input type="checkbox"/> BLUE CROSS BLUE SHIELD    E. <input type="checkbox"/> PUBLIC AGENCY (Give name) B. <input type="checkbox"/> PRIVATE INSURANCE    D. <input type="checkbox"/> EMPLOYER OR UNION    F. <input type="checkbox"/> OTHER (Explain)					
15. PATIENT'S CERTIFICATION: AUTHORIZATION TO RELEASE INFORMATION AND PAYMENT REQUEST: I certify that the information given by me in applying for payment under Title XVIII of the Social Security Act is correct. I authorize release of all records required to act on this request. I request that payment of authorized benefits be made in my behalf.					
SIGNATURE (Patient or authorized representative) (Signature by mark must be witnessed)					DATE
16. DIAGNOSES			EMPLOYMENT RELATED    A. <input type="checkbox"/> YES    B. <input type="checkbox"/> NO (If yes, give name and address of employer.)	LEAVE BLANK	
<b>REPORT OF ELIGIBILITY</b>					
A. EFFECTIVE DATE, HOSPITAL INSURANCE			J. OPEN ITEM		
B. EFFECTIVE DATE, MEDICAL INSURANCE			1. INTERMEDIARY		
C. DATE OF START OF CARE					
D. HOSPITAL INSURANCE VISITS AVAILABLE					
E. MEDICAL INSURANCE VISITS AVAILABLE					
F. LAST DISCHARGE DATE			2. PROVIDER		
G. MEDICAL PLAN DEDUCTIBLE <input type="checkbox"/> MET <input type="checkbox"/> NOT MET					
H. OUTPATIENT PSYCHIATRIC EXPENSE <input type="checkbox"/> MET <input type="checkbox"/> NOT MET			3. ADMITTED		
I. REMARKS:			4. DISCHARGED		
APPROVED BY			DATE		





## CHAPTER IV

### HOME HEALTH AGENCY BILLING PROCEDURES

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**HOME HEALTH AGENCY REPORT AND BILLING**  
**HOSPITAL AND MEDICAL INSURANCE BENEFITS—SOCIAL SECURITY ACT**

1. PATIENT'S LAST NAME			FIRST NAME		MI	2. HEALTH INSURANCE CLAIM NUMBER		
3. PATIENT'S ADDRESS (Street number, City, State, Zip Code)						4. DATE OF BIRTH		5. SEX <input type="checkbox"/> M <input type="checkbox"/> F
6. HOME HEALTH AGENCY NAME AND ADDRESS				7. PROVIDER NO.		9. NAME AND ADDRESS OF ATTENDING PHYSICIAN		
				8. MEDICAL RECORD NO.				
10. DATE CARE STARTED		11. NAME AND ADDRESS OF INSTITUTION, IF ANY, CARING FOR CONDI- TION LATER REQUIRING HOME HEALTH SERVICES				12. VERIFIED DATES OF STAY IN ITEM 11 FROM TO		13. DATE HOME HEALTH PLAN ESTABLISHED
14. PAYMENT SOURCE FOR CHARGES TO PATIENT								
A. <input type="checkbox"/> SELF OR FAMILY    C. <input type="checkbox"/> BLUE CROSS BLUE SHIELD    E. <input type="checkbox"/> PUBLIC AGENCY (Give name)								
B. <input type="checkbox"/> PRIVATE INSURANCE    D. <input type="checkbox"/> EMPLOYER OR UNION    F. <input type="checkbox"/> OTHER (Explain)								
15. PATIENT'S CERTIFICATION: AUTHORIZATION TO RELEASE INFORMATION AND PAYMENT REQUEST: I certify that the information given by me in applying for payment under Title XVIII of the Social Security Act is correct. I authorize release of all records required to act on this request. I request that payment of authorized benefits be made in my behalf.								
SIGNATURE (Patient or authorized representative) (Signature by mark must be witnessed)								DATE
16. DIAGNOSES				EMPLOYMENT RELATED    A. <input type="checkbox"/> YES    B. <input type="checkbox"/> NO (If yes, give name and address of employer.)				LEAVE BLANK
17. STATEMENT COVERS PERIOD		18. DATE OF FIRST VISIT		DATE OF LAST VISIT		19. PATIENT		20. DATE APPLICABLE TO ITEM 19
FROM	TO					<input type="checkbox"/> DIS-CHARGED <input type="checkbox"/> STILL RECEIVES SERVICES <input type="checkbox"/> DIED <input type="checkbox"/> VISITS EXHAUSTED		
21. STATEMENT OF SERVICES RENDERED		POST-HOSPITAL PLAN		MEDICAL PLAN		22. POST-HOSPITAL PLAN		23. MEDICAL PLAN
PRIMARY PURPOSE OF VISIT		NO. VISITS	CHARGES	NO. VISITS	CHARGES	A. TOTAL CHARGES		A. VERIFIED DEDUCTIBLE
A. Skilled Nursing Care			\$		\$			
B. Physical Therapy						B. REIMBURSEMENT RATE		B. VERIFIED COINSURANCE
C. Speech Therapy								
D. Occupational Therapy						C. REIMBURSEMENT AMT. A TIMES B		C. TOTAL CHARGES
E. Medical Social Services								D. REIMBURSEMENT RATE
F. Home Health Aide								
G. Other Visits (Specify)								
H. Total No. of Units of Service								E. C TIMES D
I. Charge per unit of Service \$								F. E LESS A
J. TOTALS			\$		\$			G. REIMBURSEMENT AMT. 80% OF F
K. Other (Specify)								H. REFUND TO PATIENT
L. TOTAL CHARGES			\$		\$			I. NET AMOUNT TO AGENCY, G LESS H
M. AMOUNT PAID BY PATIENT					\$			
I certify that required physician's certification and recertifications are on file.								
SIGNATURE OF HOME HEALTH AGENCY REPRESENTATIVE				DATE FORWARDED		APPROVED BY		DATE APPROVED



## CHAPTER IV

### HOME HEALTH AGENCY BILLING PROCEDURES

#### 400. INTERVIEWING THE PATIENT ABOUT HIS DEDUCTIBLE STATUS

If it is apparent that the home health services will be charged to supplementary medical insurance rather than to hospital insurance, i.e., there was no prior hospital or extended care facility stay, or the plan was not established within 14 days of discharge, the home health agency will want to discuss the patient's deductible status with him or his representative. (For more detailed information about the deductible, see § 220.1.)

Before the home health agency attempts to collect the \$50 deductible or any portion of it, it should satisfy itself that the deductible has not been met. This should be done by a careful interview with the patient, or a member of his family or other person if he is unable to conduct his own affairs, and by reference to the intermediary's reply to the start of care notice.

The intermediary's reply to the start of care notice will indicate whether the deductible has been met or not met. However, if the reply indicates that the deductible has not been met, there will be no indication of the remaining expenses needed to satisfy the deductible. The patient, in that event, may have a Notice of Hospital or Medical Insurance Utilization or Explanation of Benefits indicating what part of the deductible he has met. If he has such a notice, the home health agency may collect from the patient the portion of the deductible not met. If the patient has bills for other expenses which could meet the deductible he should submit them promptly to the medical insurance carrier and it will not be necessary for the agency to collect any part of the deductible.

When the intermediary receives the agency's billing, it will query the Social Security Administration central record, and if the deductible is not met, will be given the amount remaining to be met.

Any overpayments by the patient for the deductible, discovered when the intermediary verifies the status of the deductible with the Social Security Administration, will be refunded to the patient by the intermediary and the agency payment adjusted accordingly.

If the agency collects less than is due, the intermediary will notify it of the amount remaining to be collected on the deductible after processing the bill.

**400.1 List of Authorized Signatories.**—Each home health agency should submit to its intermediary

a listing of officials it has authorized to sign and certify bills and supporting statements. The listing should be kept current.

#### 402. COMPLETION OF BILLING PORTION OF FORM SSA-1487 BY THE HOME HEALTH AGENCY

The lower section of the report and billing form is designed as a bill for services furnished to the patient. You may submit a billing on a regular basis before the allowable visits are exhausted. However, you should always submit a billing when services are terminated, visits are exhausted, or charging of visits is to be changed from posthospital to medical, or vice versa. Use a new form to switch from posthospital plan visits to medical plan visits, or vice versa. **Do not** report posthospital plan and medical plan services on the same billing form.

The instructions for completing items 1 through 16 of the form are contained in § 310.1.

If you submit billings before the patient is discharged, items 9, 11, 12, 15, and 16 may be omitted for second and subsequent billings from your agency which are based on the same physician's plan.

**Item 17. Statement Covers Period.** Show the beginning and ending dates of the period covered by this statement.

The beginning date will normally be the date of the patient's first chargeable visit under either hospital insurance or medical insurance. If charges are being made under the medical plan, the beginning date should be no earlier than the patient's effective date of entitlement to medical insurance benefits, even though the care may have started before that date. If reimbursable services are furnished which are not charged as visits and are incurred before the first visit, the beginning date will be the date the services were first furnished.

For the ending date, show the date of the last visit before death or termination of services, or, in the case of interim billing, the last visit for which current billing is being made.

**Item 18. Dates of Visits.** Show the dates of the first and last visits of the billing period as charged to the posthospital plan or the medical plan. Bear in mind that the posthospital plan pays only for 100 visits

or less in the year after the patient is discharged from a hospital or extended care facility, and that under medical insurance there is a limit of 100 visits in the calendar year.

**Items 19 and 20. Discharge Information.** Indicate in item 19 whether at the end of the billing period the patient was discharged, died, is still receiving services, or his benefits were exhausted. Show the applicable date in item 20 unless the patient is still receiving services.

**Item 21. Statement of Services Rendered.** Based on the information you furnished on the start of care notice and other information, the intermediary will advise you on how visits are to be charged. If the first billing is under the posthospital plan, continue charging visits to the posthospital plan until the patient is discharged or the allowable visits are exhausted, whichever occurs first. If the allowable visits under the posthospital plan are used up and the patient is still receiving services, charge subsequent visits to the medical plan if the beneficiary is entitled to medical insurance and has visits available for the current year.

Any items or services which are covered as home health services under the law and which are furnished at a hospital, extended care facility, or rehabilitation center, but billed through the home health agency should be shown on the billing form as if those items or services were furnished directly by the home health agency itself.

Always show the number of visits by qualified health workers by category. Visits are defined in § 218.1. If the specialty of the health worker is not shown in A through F (e.g., intern or resident-in-training), show it in G. In addition, show the charges for A through G if the agency charges a separate fee for each service. If the agency charges a package fee for all types of services, show the total units (visits, days, weeks, depending in how the charges are made) in H and charge per unit of service in I.

Always show the total visits and the total charges for visits in J. Use K to specify any additional charges which are not classified as visits and are not included in the visit charges, such as medical supplies and equipment, for which a separate charge is being made. Fully describe any supplies or equipment of this nature.

Show the grand total of all covered charges in L.

If the patient paid any amount toward the deductible and/or coinsurance before the billing is submitted to your intermediary, enter the total amount paid by him or on his behalf in M.

**Item 22. Computing Reimbursement Under Posthospital Plan.** The computation may be made by the agency and reviewed by the intermediary or made solely by the intermediary.

**Item A:** Show the total charges from item 21–L made to the posthospital plan.

**Item B:** Show the agreed-upon reimbursement rate,

which will be a percentage that the agency's charges bear to costs. The percentage is determined by the intermediary by whatever evidence is available.

**Item C:** Multiply the total charges by the reimbursement rate.

**Item 23. Computing Reimbursement Under the Medical Plan.** It is suggested that the agency not make this computation except when it knows that the patient's \$50 deductible is already met.

**Item A:** Enter the amount of the deductible, if any, applicable to this bill. This will be done by the intermediary when the deductible has not been met.

**Item B:** Subtract A from the total medical plan charges in 21–L and multiply the difference by 20 percent. This is the coinsurance amount for which the patient is responsible.

**Item C:** Enter the total charges under the medical plan from line 21–L.

**Item D:** Enter the reimbursement rate. It will be the same percentage that is used for the posthospital plan.

**Item E:** Multiply the total charges by the reimbursement rate.

**Item F:** Subtract any applicable deductible from the figure in E.

**Item G:** Multiply the figure in F by 80 percent.

**Items H and I:** These should not be used by the agency. The intermediary will use these items when it is determined that the patient has overpaid the deductible and coinsurance, and is refunding the overpayment to him.

**Certification and Signature Line.** For payment to be made, an agency representative must certify that the required physician's certification and recertifications are on file. Show the date the bill is forwarded to your intermediary (or to SSA if you deal directly).

#### 403. DISPOSITION OF COPIES OF COMPLETED FORMS

Retain the copy designated "Home Health Agency Copy" and submit the remaining copies to your intermediary (or SSA in direct dealing situations). The remaining copies to be submitted to the intermediary or SSA constitute the following:

1. The original copy which is maintained in the intermediary's (or SSA's) files.

2. The copy designated "Social Security Administration Copy."

3. The copy designated "Carrier Copy." (This copy is forwarded to the Part B carrier by the Part A intermediary (or SSA) and is used for informational purposes for processing Part B claims.) One or both copies designated "Admission Copy" used for notice of start of care purposes may or may not be transmitted to the intermediary or SSA, depending upon individual arrangements provided for transmission of notice of start of care data. Where the notice of admission copies of the form have not been used for notice of start of care purposes they may be discarded.















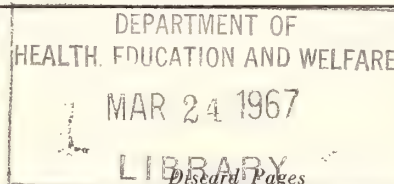
# HOME HEALTH AGENCY MANUAL REVISION

U.S. DEPARTMENT OF  
HEALTH, EDUCATION, AND WELFARE  
SOCIAL SECURITY ADMINISTRATION  
HIM-11

HEALTH INSURANCE FOR THE AGED

FEBRUARY 1967

NO. 2



*New Material*  
Table of Contents, Chapter II  
Sec. 200—218.1

*Replacement Pages*  
11—12  
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*Discard Pages*

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This is the first revision to the Home Health Agency Manual to be issued in this format. Revision No. 1 was issued June 27, 1966; it specified that the day of discharge is not counted as a day in defining three-day hospital stay as a qualifying condition for Part A home health services.

This revision makes the following changes.

**Sec. 205.**—A paragraph has been added indicating that the salaries of home health agency personnel such as psychologists inhalation therapists, and nutrition personnel employed to assist in the overall operation of the program are includable as reimbursable agency costs. However, visits by such personnel to the patient's home are not covered and do not count against the beneficiary's visit limitation.

**Sec. 205.1A.**—The terms licensed practical nurse and licensed vocational nurse may be used interchangeably.

**Sec. 205.1B.**—This is a new subsection explaining the coverage of student nurse services. The last paragraph concerning the billing for student nurse services has been included in this revision pending issuance of the forthcoming revised Chapter IV.

**Sec. 205.2D.**—The services of aides to physical, speech, and occupational therapists and other supplementary personnel are covered.

**Sec. 205.6.**—The services of hospital interns and residents to home health beneficiaries are covered under Part B when the intern or resident is not under an approved teaching program.

**Sec. 208.5.**—If an individual is an inpatient of a hospital or extended care facility, he does not qualify for coverage of home health services since these services must generally be furnished in the patient's residence. This section explains when an institution may not be considered the patient's residence.

**Sec. 208.6.**—The coverage of services outside the patient's residence is clarified. The relationship of his ability to travel for such services and the requirement that he be essentially homebound is explained.

**Sec. 210.1.**—Explains the effect of the spell of illness on coverage of home health services under Part A.

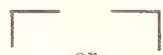
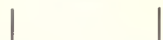
**Sec. 210.2.**—Explains the requirements which a hospital and extended care facility must meet to satisfy the prior-stay requirement. The spell of illness and 3-day hospital stay requirement need not be met by the same hospital stay.

**Sec. 210.3.**—In determining whether the 14-day requirement for plan establishment is met, the day of discharge from the inpatient stay is not counted in the 14 days. Services furnished after discharge and before the plan has been reduced to writing are covered if the plan is reduced to writing within the required 14-day period.

**Sec. 215.**—Explains the conditions under which a new series of Part A visits is established and the conditions which will reestablish the 1-year period during which unused visits in an existing series may be utilized.

Arthur E. Hess  
*Director, Bureau of Health Insurance*

Changed material is indicated in the margin of a page in the following manner:

	=	Line on which change begins
or		
	=	Line on which change ends

Revision transmittal sheets should be filed at the end of the manual as a record of receipt.

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## Chapter II

### COVERAGE OF HOME HEALTH SERVICES

#### 200. HOME HEALTH AGENCY

A home health agency is a public agency or private organization, or a subdivision of such an agency or organization, which meets the following requirements:

A. It is primarily engaged in providing skilled nursing services and other therapeutic services, such as physical, speech, or occupational therapy, medical social services, and home health aide services. A public or voluntary nonprofit health agency may qualify by—

1. furnishing both skilled nursing and at least one other therapeutic service directly to patients, or

2. furnishing directly either skilled nursing services or at least one other therapeutic service and having arrangements with another public or voluntary nonprofit agency to furnish the services which it does not provide directly.

A proprietary agency can qualify only by providing directly both skilled nursing services and at least one other therapeutic service.

B. It has policies established by a professional group associated with the agency or organization (including at least one physician and at least one registered professional nurse) to govern the services, and provides for supervision of such services by a physician or a registered professional nurse.

C. It maintains clinical records on all patients.

D. It is licensed in accordance with State or local law or is approved by the State or local licensing agency as meeting the licensing standards (where State or local law provides for the licensing of such agencies or organizations).

E. It meets other conditions found by the Secretary of Health, Education, and Welfare to be necessary for health and safety.

A private organization which is not exempt from Federal income taxation under section 501 of the Internal Revenue Code of 1954 (sometimes referred to as a "proprietary" organization) must be licensed pursuant to State law. If the State has no licensing law for such organizations, a proprietary agency cannot participate in the health insurance program.

For services under hospital insurance, the term "home health agency" does not include any agency or organization which is primarily for the care and treatment of mental disease. There is no such restriction under supplementary medical insurance.

**200.1 Subdivision of Agencies.**—When the subdivision of an agency, such as the home care department of a hospital or the nursing division of a health department, wishes to participate as a home health agency, the subdivision must meet the conditions of participation and must maintain records in such a way that subdivision activities and expenditures attributable to services provided under the health insurance program are identifiable.

#### 200.2. Arrangements by Home Health Agencies

A. Arrangements made by a home health agency with others to furnish items or services must be such that receipt of payment by the home health agency for the services (whether in its own right or as agent) discharges the liability of the beneficiary or any other person to pay for the services.

Whether the services and items are furnished by the home health agency itself or by another agency under arrangements made by the home health agency, both must agree not to charge the patient for covered services and items and must also agree to return money incorrectly collected.

There are 3 situations in which a home health agency may have arrangements with another health organization or person to provide home health services to patients:

1. Where an agency or organization, in order to be approved to participate in the program, makes arrangements with another agency or organization to provide the nursing or other therapeutic services which it cannot provide directly.

2. Where an agency or organization, which is already approved for participation, makes arrangements with others to provide services it does not provide.

3. Where an agency or organization, which is already approved for participation, makes arrangements with a hospital, extended care facility, or rehabilitation center for services on an outpatient basis because the services involve the use of equipment which cannot be made available to the patient in his place of residence.

**B. If an agency's subdivision** (acting in its capacity as a home health agency) makes an arrangement with its parent agency for the provision of these items and/or services there need not be a contract or formal agreement. If, however, the arrangement is made between the home health agency and another provider participating in the health insurance program (hospital, extended care facility, or home health agency), there must be a written statement regarding the services to be provided and the financial arrangements.

**C. If the arrangements are with an agency or organization which is not a qualified provider of services**, there must be a written contract which includes all of the following:

1. A description of the services to be provided.
2. The duration of the agreement and how frequently it is to be reviewed.
3. A description of how personnel will be supervised.
4. A statement that the contracting organization will provide its services in accordance with the plan of treatment established by the patient's physician in conjunction with the home health agency's staff.
5. A description of the contracting organization's standards for personnel, including qualifications, functions, supervision, and inservice training.
6. A description of the method of determining reasonable costs and reimbursements by the home health agency for the specific services to be provided by the contracting organization.
7. An assurance that the contracting organization will comply with Title VI of the Civil Rights Act.

**200.3 Rehabilitation Centers.**—When the services are of such a nature that they cannot be administered at the patient's residence and are administered at a rehabilitation center which is not participating in the program as a hospital, extended care facility, or home health agency, the rehabilitation center must meet certain standards. The physical plant and equipment of such a rehabilitation center must meet all applicable State and local legal requirements for construction, safety, health, and design, including safety, sanitation and fire regulations, building codes, and ordinances.

## 205. COVERED HOME HEALTH SERVICES

A patient may be eligible for home health service under both hospital insurance and supplementary medical insurance. All services furnished by a home health agency, whether provided directly by the home health agency or under arrangements with others, must be furnished by or under the supervision of qualified personnel. The salaries of home health agency personnel employed to assist in the overall operation of the program, such as psychologists, inhalation therapists, and nutrition personnel, are includable in computing the agency's reimbursable costs. However, payment may not be made for individual visits by such personnel to a beneficiary's home, and if such a visit is made, it would not count against the beneficiary's "visit" limitation.

The following sections discuss covered home health services under both programs when provided by the home health agency, or by others under arrangements with the home health agency.

**205.1 Nursing care** is covered when provided on a part-time or intermittent basis.

**A. Registered and Practical Nurses.**—Nursing care is professional nursing service provided by a registered professional nurse in accordance with a physician's orders, or the practical nursing service provided by either a licensed practical or licensed vocational nurse (these terms may be used interchangeably) working under the supervision of a registered professional nurse. (See "Conditions of Participation for Home Health Agencies" for qualifications required for nurses.)

**B. Student Nurses.**—If a home health agency participating in the training of **student nurses** assigns a student nurse to provide nursing services in the patient's home, the costs of her services are reimbursable if the following conditions are met:

1. The student nurse is enrolled in a diploma or baccalaureate degree program approved by the National League for Nursing (a registered professional nurse receiving additional training is not considered a student nurse); and
2. The student nurse's services are "skilled nursing services" as defined in the "Conditions of Participation for Home Health Agencies" except when the lack of a license limits her activities; and
3. Her services are performed under the supervision of a registered professional nurse who is either an employee of the home health agency or the school of nursing in which the student is enrolled. The supervising nurse need not accompany the student on each visit. (See § 218.2 for counting of visits when



the supervisor accompanies the student on a visit.)

The number of visits by and charges for services of an unaccompanied student nurse should be entered in item 21(G) of Form SSA-1487 (Home Health Agency Report and Billing). The visits should be designated as "Student Nurse." When a registered nurse who is an employee of the home health agency accompanies the student to observe her, the visit should be counted as a student visit and entered in item 21(G). If, however, the purpose of the visit is for the student to observe the registered nurse, the visit and charge should be entered in item 21(A).

**C. Part-Time or Intermittent Care.**—Part-time or intermittent nursing care is usually service for a few hours a day several times a week. Occasionally, service for a full day may be provided for a short period when, because of unusual circumstances, neither the alternative of part-time care nor hospitalization is feasible.

**205.2 Physical, Speech, and Occupational Therapy.**—Physical, speech, and occupational therapy furnished by the home health agency is covered when provided in accordance with a physician's orders and by or under the supervision of a qualified therapist.

#### **A. Physical Therapy**

Physical therapy is service provided in accordance with a physician's orders by or under the supervision of a qualified physical therapist.

A qualified physical therapist is licensed or registered by the State when licensure laws are applicable, and meets the following criteria:

1. Graduation from a physical therapy curriculum approved by the American Physical Therapy Association from 1928 to 1936, or by the Council on Medical Education and Hospitals of the American Medical Association from 1936 to 1960, or by the Council on Medical Education of the American Medical Association in collaboration with the American Physical Therapy Association since 1960; or

2. Membership in the American Physical Therapy Association or registration by the American Registry of Physical Therapists; or

3. If the physical therapist was trained outside the United States:

- a. Graduation since 1928 from a physical therapy curriculum approved in the country in which the curriculum was located, and the curriculum must have been in a country in which there is a member organization of the World Confederation for Physical Therapy; and

- b. Membership in a member organization of the World Confederation for Physical Therapy; and

- c. Completion of 1 year's experience under the supervision of an active member of the American Physical Therapy Association; and

- d. Successful completion of a qualifying examination as prescribed by the American Physical Therapy Association.

An individual who graduated from any school before its physical therapy curriculum was approved by the appropriate organization mentioned in 1. above is not a qualified physical therapist unless, of course, he is a member of the American Physical Therapy Association or is registered by the American Registry of Physical Therapists.

#### **B. Speech Therapy**

Speech therapy, that is service in speech pathology or audiology, is service provided in accordance with a physician's orders and furnished by or under the supervision of a qualified speech therapist.

A qualified speech therapist is one certified by the American Speech and Hearing Association, or who has completed the academic requirements and is in the process of accumulating the necessary supervised work experience required for such certification. (The term "speech therapist" includes a speech pathologist.)

#### **C. Occupational Therapy**

Occupational therapy is service given in accordance with a physician's orders and by or under the supervision of a qualified occupational therapist.

A qualified occupational therapist is one registered by the American Occupational Therapy Association or is a graduate of a program in such therapy approved by the Council on Medical Education of the American Medical Association in collaboration with the American Occupational Therapy Association, and is engaged in the required supervised clinical experience period prerequisite to the registration by the American Occupational Therapy Association.

An occupational therapy assistant is one who works under the supervision of a qualified occupational therapist and has successfully completed a training course approved by the American Occupational Therapy Association, and is certified by that body as a certified occupational therapy assistant.

**D. Aides to Physical, Speech, and Occupational Therapists and Other Supplementary Personnel.** The cost of the services of aides and other personnel providing supplementary services is covered when such an aide or other person is trained and supervised by appropriate professional personnel.

**205.3 Medical Social Services.**—These services must be under the direction of a physician and must be given by or under the supervision of a qualified medical or psychiatric social worker.

A qualified medical or psychiatric social worker is a graduate of a school of social work accredited by the Council on Social Work Education, and has had social work experience in a hospital, outpatient clinic, medical rehabilitation, or medical care program.

A social work assistant is one who works under the supervision of a qualified medical or psychiatric social worker, and has a baccalaureate degree, and has received or is receiving on-the-job training in medical social service tasks and assignments from the agency.

**205.4 Part-Time or Intermittent Services of a Home Health Aide.**—The services of a home health aide are directed toward the personal care of a patient and are given in accordance with physician's orders and under the supervision of a registered professional nurse, or, if appropriate, a physical, speech, or occupational therapist. The assignment of a home health aide to a particular case must be made in accordance with a plan of treatment. The specific personal care services to be provided by the home health aide must be determined by a registered professional nurse, and not by the home health aide.

The duties performed are essentially personal health care for the patient, i.e., helping the patient to bathe, get in and out of bed and exercise, retraining the patient in the necessary household skills, assisting him with medications that ordinarily are self-administered and which have been specifically ordered by a physician, and performing incidental household services which are essential to the patient's health care at home and necessary to prevent or postpone institutionalization. The discussion of "part-time or intermittent" services in § 205.1 above is also applicable to home health aides.

**205.5 Medical Supplies (Except for Drugs and Biologicals) and the Use of Medical Appliances.**

—Medical supplies are items which are essential to enable the home health agency to carry out effectively in the home the kinds of care which the physician has ordered. Medical supplies include (but are not limited to) gauze, cotton, adhesive bandage, surgical dressings, catheters, surgical gloves, rubbing alcohol, irrigating solutions, intravenous fluids, and oxygen.

Medical appliances are items owned or rented by the home health agency and loaned to the patient to facilitate his treatment and rehabilitation. They include, but are not limited to, such items as bedpans,

wheelchairs, crutches, hospital beds, trapeze bars, oxygen tents, intermittent positive pressure machines, and air pressure mattresses.

Drugs and biologicals are excluded from coverage as items or services administered by home health agencies, under either hospital insurance or medical insurance. They may, in certain cases, be covered under medical insurance, when administered by a physician as a part of his professional services and are not capable of being self-administered.

**205.6 Services of Interns and Residents.**—

Home health services include the medical services of interns and residents-in-training under an approved hospital teaching program (if the agency has an affiliation with or is under common control of a hospital providing such medical services). "Approved" means approved by the Council on Medical Education of the American Medical Association, or in the case of an osteopathic hospital, the Committee on Hospitals of the Bureau of Professional Education of the American Osteopathic Association, and, in the case of an intern or resident-in-training in the field of dentistry, approved by the Council on Dental Education of the American Dental Association. Reimbursement is provided under Part B for the services other hospital interns and residents furnish to beneficiaries receiving home health services.

**205.7 Outpatient Services.**—

Outpatient services include any of the items or services described above which are provided under arrangements on an outpatient basis at a hospital, extended care facility, rehabilitation center, or outpatient department affiliated with a medical school, and (1) which require equipment not readily available at the patient's place of residence or (2) which are furnished while he is at the facility to receive the services described in (1). The hospital, extended care facility, or outpatient department affiliated with a medical school must all be qualified providers of services. However, there are special provisions for the use of the facilities of rehabilitation centers (see § 200.3). The cost of transporting an individual to a facility cannot be reimbursed.

**208. CONDITIONS FOR COVERAGE FOR HOME HEALTH SERVICES UNDER BOTH HOSPITAL AND MEDICAL INSURANCE**

**208.1 Patient Must Be Under Care Of A Physician.**—

Items and services must be furnished to an individual who is under the care of a physician. This physician may be the patient's private physician; or, a physician on the staff of the home health agency; or



a physician working under an arrangement with the institution which is the patient's residence; or if the agency is hospital-based, a physician on the hospital or agency staff. The attending physician establishes the plan of treatment and also certifies to the necessity for home health services.

#### **208.2 Services Must Be Furnished By Agency.**

—Items and services must be furnished by a participating home health agency or by others under arrangements made by the agency. (See § 200.2 for definition of “under arrangements.”)

#### **208.3 Services Must Be Furnished Under A Plan.**

—Items and services must be furnished under a plan established and periodically reviewed by a physician and which relates the items and services to the patient's condition. A plan must be reduced to writing by the physician and be made available to the home health agency which has accepted the patient as a client. (See § 210.3 for coverage of Part A services rendered before the plan is reduced to writing.) Part B home health services furnished before the plan is reduced to writing are covered if authorized by a physician. However, the plan must have been reduced to writing prior to the submission of the bill. The plan must specify the types of services required and should, as far as possible, provide a long-range forecast of likely changes in the patient's condition. It should include diagnosis, when and what nursing services are needed, drugs and medications to be used, diet, activity permitted, rehabilitation, therapy needed, medical social services needed, home health aide services needed, and supplies and appliances needed.

The plan must be signed by the attending physician and incorporated into the agency's permanent record for the patient. Any changes must be made in writing and signed by the physician or by a registered professional nurse on the staff of the agency pursuant to the physician's oral orders. All changes in orders for dangerous drugs and narcotics must be signed by the physician.

The plan must be reviewed by the attending physician, in consultation with agency professional personnel, at such intervals as the severity of the patient's illness requires but at least every 2 months. Each review of a patient's plan should contain the initials of the physician and show the date performed. The agency's record need not be forwarded to the intermediary for review but will be retained in the agency's file.

When an individual has coverage under both Part A and Part B, home health plans under both parts should not operate concurrently. For example, a plan

of treatment is established after hospitalization for a condition for which the patient was hospitalized, and the patient later requires home health services for a condition unrelated to the previous hospitalization but while the original plan of treatment is still in effect. The original plan of treatment should be modified to take into account the required home health services for the condition not related to previous hospitalization. Otherwise, there would be administrative difficulties in counting home health visits, particularly if two home health agencies become involved. Of course, if the patient does not have Part B coverage, the original plan of treatment cannot be modified to provide home health services not related to prior hospitalization.

When benefits under hospital insurance have been exhausted and a change to benefits under medical insurance is made, it is not necessary for the physician to change the plan of treatment.

#### **208.4 Services Furnished On a Visiting Basis.**

—Items and services must be furnished on a visiting basis in the place of residence used as the individual's home (see § 208.5). There must be a medical judgment that the patient must be confined for health reasons, and requires home health services on a part-time or intermittent visiting basis, even though the patient may be ambulatory to some extent and may on occasion be able to leave his place of residence with or without aid.

**208.5 Patient's Place of Residence.**—A patient's residence is wherever he makes his home. This may be his own dwelling, an apartment, a relative's home, a home for the aged, or some other type of institution. However, an institution may not be considered a patient's residence if it:

(a) Meets at least the basic requirement in the definition of a hospital (§ 112.1), i.e., it is primarily engaged in providing by or under the supervision of physicians, to inpatients, diagnostic and therapeutic services for medical diagnosis, treatment, and care of injured, disabled, or sick persons, or rehabilitation services for the rehabilitation of injured, disabled, or sick persons, or

(b) Meets at least the basic requirement in the definition of an extended care facility (§112.2), i.e., it is primarily engaged in providing to inpatients skilled nursing care and related services for patients who require medical or nursing care, or rehabilitation services for the rehabilitation of injured, disabled, or sick persons. If a patient is transferred from a participating extended care facility to a nonparticipating part of the facility which he uses as his home, the part



will not be considered the patient's residence if it meets this requirement.

Thus, if an individual is a patient in an institution or distinct part of an institution which provides the services described in (a) or (b) above, he is not entitled to have payment made for home health services under either Part A or Part B since such an institution may not be considered his residence.

When a patient remains in a participating extended care facility following his discharge from active care, the facility may not be considered his residence for purposes of home health coverage.

#### **208.6 Services Outside the Patient's Residence.**

—If the services cannot be provided at the patient's residence because equipment is required which cannot be made available in the patient's home, they may be provided only at a hospital, extended care facility, an outpatient department affiliated with a medical school, or a rehabilitation center (see §§ 200.2A3 and 205.7). However, even in these situations **the patient must be essentially homebound** and able to manage only an occasional trip to a facility which furnishes services requiring equipment not readily available in the home. The patient's condition must be such as to prevent him from regularly making the effort which traveling from his place of residence to the appropriate facility involves, that is, leaving his home for this purpose more often than once a week. The ability to make this trip more frequently would strongly indicate that the patient no longer meets the eligibility requirements for home health services.

### **210. SPECIAL CONDITIONS FOR COVERAGE OF HOME HEALTH SERVICES UNDER HOSPITAL INSURANCE**

In addition to the conditions listed in § 208, the following conditions must be met for coverage under hospital insurance.

#### **210.1 Effect of Spell of Illness on Coverage.—**

Hospital insurance coverage extends only to that number of home health visits (100 or less) as are furnished after the beginning of one spell of illness and before the beginning of the next. It is **not** necessary that the patient still be in his spell of illness at the time the plan is established or visits begin. (See § 112.3 for definition of spell of illness and the types of institutions in which inpatient services will begin a spell of illness.)

**210.2 Prior Inpatient Stay.**—In addition to the spell of illness requirement, the law further specifies that a patient is entitled to these home health visits under hospital insurance in the year following his

discharge from a covered stay of any duration in an extended care facility or from a stay of at least 3 consecutive days in: (1) a participating hospital, or (2) a nonparticipating hospital which meets all of the conditions of participation except for the utilization review and health and safety requirements (§ 112.1). In determining whether the 3-day period of hospitalization has been met, the day of admission, **but not the day of discharge**, is counted as a hospital inpatient day.

The discharge from the hospital which is required to qualify home health services for payment under hospital insurance must have occurred after June 30, 1966, and in or after the month in which the patient attained age 65. Since the extended care facility discharge must be from a covered stay, it must have occurred after December 31, 1966. There must be an actual discharge of the patient from the hospital or extended care facility to his residence. See § 208.5 for conditions under which an institution may not be considered the patient's residence.

**Note: It is not necessary that the spell of illness and the 3-day stay requirements be met by the same hospital stay. The stay of 3 consecutive days can occur any time before the next spell of illness begins.**

The following is an example of the interrelationship of the spell of illness and prior inpatient stay requirements for coverage for a series of home health visits under hospital insurance:

X is admitted to a qualified hospital for inpatient hospital services on November 1, 1966, and is discharged on November 2, 1966, thereby beginning a spell of illness. X has no further illness until January 8, 1968. Thus, his spell of illness ended January 1, 1967, the end of the 60-day period after his hospital discharge on November 2, 1966. On January 8, 1968, he is admitted for nonemergency services to a hospital which is not participating in the program but which meets all conditions of participation other than the utilization review and health and safety requirements. This stay did not start a new spell of illness. On January 13, 1968, he is discharged to his home, and on January 20, 1968, his physician established a home health plan for him. Since the patient had a spell of illness which commenced on November 1, 1966, (even though it had ended), and has had a 3-day stay in a hospital, X is entitled to 100 home health visits in the year following his discharge on January 13, 1968, unless a new spell of illness begins before he uses all of his 100 visits. See additional examples in § 215.3.

**210.3 Fourteen-Day Limit on Plan Establishment.**—The plan for home health services (§ 208.3) must be established within 14 days after the patient's discharge from the qualifying prior inpatient stay. In determining the 14-day period, the day of discharge **is not** counted in the 14 days. For example, a patient's plan is established within 14 days if he was discharged from a hospital on August 1 and his plan was established on August 15.

In some cases services are furnished after discharge from the hospital or extended care facility and before the plan has been reduced to writing. Payment under Part A may be made for such services if authorized by a physician, provided the plan is reduced to writing within 14 days of the patient's discharge.

**210.4 Related Illness or Impairment.**—In order for home health services to be covered under hospital insurance, a doctor must certify that the patient needs intermittent nursing care or physical or speech therapy for any condition for which he was receiving inpatient hospital or extended care services.

**210.5 Transfer of Patient.**—If it becomes necessary for the patient to transfer to a different physician or home health agency (in a different locality) after the timely establishment of the required physician's plan, the original plan may be continued in the new locality if:

A. There is a referral by the patient's physician in the old locality of both the patient and the plan to a physician in the new locality.

B. The patient's physician in the new locality accepts the original plan of treatment and assumes the responsibility of conducting the required periodic reviews of the plan. The plan could be modified from time to time as determined necessary by the patient's physician in the new locality.

C. A participating home health agency in the new locality accepts the patient.

The number of posthospital home health visits already used in the old locality in the (applicable) year would be taken into account in determining when the limit of 100 visits under the hospital plan is reached.

**Example:** A health insurance beneficiary has received 40 home health visits under Part A when it is decided that his overall recovery would be hastened if he moved to a relative's home in a city 100 miles away. However, the physician who established and is reviewing his home health plan recommends that the physical therapy treatments he has been receiving be continued. A physician in the distant city concurs and agrees to

take responsibility for continuance of the plan. When the patient moves, the plan is submitted to a home health agency in that city and services continue as before. The patient is entitled to the remaining 60 home health visits in the applicable year under Part A at his new residence.

## **212. SPECIAL CONDITIONS FOR COVERAGE OF HOME HEALTH SERVICES UNDER SUPPLEMENTARY MEDICAL INSURANCE**

**212.1 Non-Eligibility under Hospital Insurance.**—For home health services to be covered under supplementary medical insurance, the patient must be currently enrolled in the medical insurance plan and where the home health services to be provided are covered under hospital insurance, not be eligible to receive such services under hospital insurance. Where a patient is eligible for home health services which are covered under both programs, the services are chargeable under hospital insurance. When the benefits payable under hospital insurance are exhausted, he may then utilize the benefits available under the supplementary medical insurance program. A plan covering services under the medical insurance program must be established by the physician, and must be reduced to writing before the agency bills for the services.

Prior inpatient care in a hospital or extended care facility **is not** required for coverage of home health services under the supplementary medical insurance plan.

**212.2 Change to Medical Insurance Home Health Services on Change of Residence.**—A patient who changes residence before exhausting his 100 home health visits under hospital insurance can receive further home health services **only** under the medical insurance program if there is no further eligibility for home health services under the hospital insurance plan. This might occur, for example, in the following situations:

A. The physician in the old locality terminates the posthospital home health plan, or

B. There is no physician in the new locality who agrees to accept both the patient and the plan, e.g., the new physician wants to establish an entirely new plan.

For coverage under medical insurance in these circumstances, the new physician must establish a new plan.

See section 210.5 for conditions under which home health services under hospital insurance may continue in the new locality.



## 215. DURATION OF HOME HEALTH SERVICES

**215.1 Duration of Home Health Services Under Hospital Insurance.**—Under hospital insurance the patient is entitled to up to 100 visits in the 1-year period after the **most recent discharge** from a qualifying inpatient stay (§210.2) and before a new spell of illness begins (§210.1).

If before a series of home health visits is completed, a patient receives inpatient services which start a new spell of illness, the series of visits is terminated. Both the “prior inpatient stay” (§ 210.2) and “timely establishment of plan” (§ 210.3) requirements must be met in the new spell of illness to provide coverage for a new series of home health visits.

If, during the same spell of illness, the home health patient returns to a hospital or extended care facility for a stay which meets the prior-stay requirement, a new one-year period for his Part A visits is established dating from his latest discharge. The total number of visits available before the next spell of illness begins remains unchanged.

In rare cases a home health patient may return to a hospital for a stay which satisfies the prior-stay requirement but does not begin a new spell of illness, i.e., a 3-day noncovered stay in a nonparticipating hospital which meets all the conditions of participation except for the utilization review and health and safety requirements (see § 112.1). In this situation a new one-year period begins with the discharge and the number of visits remains unchanged.

The end of the year for hospital insurance purposes is determined as follows:

Count 365 days (366 when February 29 is included) beginning with the later of the following:

- a. The date of discharge after June 30, 1966, from a 3-day stay in any hospital, or
- b. The date of discharge after December 31, 1966, from an extended care facility stay for which post-hospital extended care benefits were payable on the patient's behalf.

## 215.2 Duration of Home Health Services Under Supplementary Medical Insurance.—

Under **supplementary medical insurance** a patient is entitled to 100 visits in a calendar year. Entitlement to visits under supplementary medical insurance is related to the calendar year and is unaffected by the patient's spell(s) of illness. If entitled to services under both hospital insurance and supplementary medical insurance, the visits must first be charged against the hospital insurance.

The end of the year under medical insurance is December 31.

## 215.3 Examples of Duration of Services Under Hospital and Medical Insurance.—

**Example 1:** Jones is hospitalized on February 10 and discharged on March 15, 1967; he has no other hospital or extended care facility stay in 1967 or 1968. He has 100 home health visits beginning the latter part of March and ending on February 20, 1968. All 100 visits are paid for **under hospital insurance** since the 1-year period runs from March 15, 1967, the date of the hospital discharge, to March 14, 1968. Although Jones' spell of illness ended on May 14, 1967, 60 days after the hospital discharge, home health eligibility was unaffected since a new spell of illness did not **begin** subsequently.

**Example 2:** Robinson was an inpatient in a hospital four times during the same spell of illness, i.e., there was no period of 60 consecutive days during which he was not hospitalized. He was discharged from the hospital, which meets the requirements to qualify subsequent home health services for payment under hospital insurance, on March 15, 1967, May 14, 1967, July 13, 1967, and September 10, 1967. Each hospital stay was for at least 3 consecutive days except the last one. He had home health visits beginning with May 23, 1967, based on a plan established after his hospital discharge of May 14. The 1-year period for home health services **under hospital insurance** began May 14, 1967, the date of his most recent discharge (in relation to the first home health visit in the spell of illness) from a hospital after a stay of 3 days; it can end no later than July 13, 1968, 1 year after the latest discharge from a hospital stay of at least 3 consecutive days. Thus, in some situations, the “1-year period” during which an individual may have up to 100 home health visits may in fact exceed a year overall.

**Example 3:** Smith is hospitalized on February 10 and discharged on March 15. He reenters the hospital on July 4. He had 30 home health visits between March 15 and July 4. Since he had been out of the hospital for more than 60 days after his discharge on March 15, a new spell of illness began on July 4, when he reentered the hospital. Therefore, he is not entitled to any additional home health visits **under hospital insurance** based on his February–March hospital stay. However, an additional 100 home health visits under hospital insurance may begin based on his hospitalization beginning July 4, if he is confined for at least 3 days. If it is for less than 3 days, he will not



qualify for home health visits under hospital insurance in the new spell of illness. However, if he is enrolled in the supplementary medical insurance program he is entitled to an additional 100 visits **under Part B** through December 31, subject to the deductible provisions.

**Example 4:** Brown is discharged from a hospital on February 15, 1967, after a 3-day stay. He begins receiving home health visits on February 18, 1967. He has until February 14, 1968, to use his 100 visits **under hospital insurance**. In July, however, he receives his 100th visit, exhausting the number of visits to which he is entitled under hospital insurance. Coverage of his home health visits may continue unbroken, if he is enrolled under supplementary medical insurance. In that event, he may receive an additional

100 visits **under medical insurance** through December. In January 1968, he becomes entitled to an additional 100 visits under supplementary medical insurance for the calendar year of 1968.

## **218. COUNTING VISITS UNDER THE HOSPITAL AND MEDICAL PLANS**

The number of visits are counted in the same manner under both the hospital plan and medical plan.

**218.1 Visit Defined.**—A visit is a personal contact in the place of residence of a patient made for the purpose of providing a covered service by a health worker on the staff of the home health agency or by others under contract or arrangement with the home health agency; or a visit by a patient on an outpatient basis to a hospital, extended care facility, or rehabilitation

(Continued on page 19)











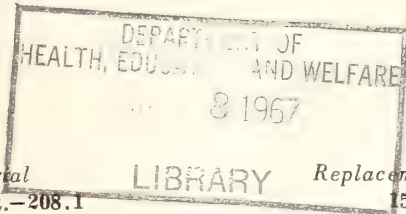
# HOME HEALTH AGENCY MANUAL REVISION

U.S. DEPARTMENT OF  
HEALTH, EDUCATION, AND WELFARE  
SOCIAL SECURITY ADMINISTRATION  
HIM-11

HEALTH INSURANCE FOR THE AGED

MAY 1967

NO. 3



*New Material*  
Sec. 205.1 Cont.—208.1

*Replacement Pages*  
LIBRARY 15—16

*Discard Pages*  
15—16

**Sec. 205.1B.**—This revision removes the distinction in billing for student nurse visits and other skilled nursing visits. Student nurse visits will now be billed under 21A of the Home Health Agency Report and Billing.

Thomas M. Tierney, Director  
Bureau of Health Insurance

Changed material is indicated in the margin of a page in the following manner:

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or  
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Revision transmittal sheets should be filed at the end of the manual as a record of receipt.





the supervisor accompanies the student on a visit.)

The number of visits by and charges for services of a student nurse should be entered in item 21(A) of Form SSA-1487 (Home Health Agency Report and Billing).

**C. Part-Time or Intermittent Care.**—Part-time or intermittent nursing care is usually service for a few hours a day several times a week. Occasionally, service for a full day may be provided for a short period when, because of unusual circumstances, neither the alternative of part-time care nor hospitalization is feasible.

**205.2 Physical, Speech, and Occupational Therapy.**—Physical, speech, and occupational therapy furnished by the home health agency is covered when provided in accordance with a physician's orders and by or under the supervision of a qualified therapist.

#### **A. Physical Therapy**

Physical therapy is service provided in accordance with a physician's orders by or under the supervision of a qualified physical therapist.

A qualified physical therapist is licensed or registered by the State when licensure laws are applicable, and meets the following criteria:

1. Graduation from a physical therapy curriculum approved by the American Physical Therapy Association from 1928 to 1936, or by the Council on Medical Education and Hospitals of the American Medical Association from 1936 to 1960, or by the Council on Medical Education of the American Medical Association in collaboration with the American Physical Therapy Association since 1960; or

2. Membership in the American Physical Therapy Association or registration by the American Registry of Physical Therapists; or

3. If the physical therapist was trained outside the United States:

- a. Graduation since 1928 from a physical therapy curriculum approved in the country in which the curriculum was located, and the curriculum must have been in a country in which there is a member organization of the World Confederation for Physical Therapy; and

- b. Membership in a member organization of the World Confederation for Physical Therapy; and

- c. Completion of 1 year's experience under the supervision of an active member of the American Physical Therapy Association; and

- d. Successful completion of a qualifying examination as prescribed by the American Physical Therapy Association.

An individual who graduated from any school before its physical therapy curriculum was approved by the appropriate organization mentioned in 1. above is not a qualified physical therapist unless, of course, he is a member of the American Physical Therapy Association or is registered by the American Registry of Physical Therapists.

#### **B. Speech Therapy**

Speech therapy, that is service in speech pathology or audiology, is service provided in accordance with a physician's orders and furnished by or under the supervision of a qualified speech therapist.

A qualified speech therapist is one certified by the American Speech and Hearing Association, or who has completed the academic requirements and is in the process of accumulating the necessary supervised work experience required for such certification. (The term "speech therapist" includes a speech pathologist.)

#### **C. Occupational Therapy**

Occupational therapy is service given in accordance with a physician's orders and by or under the supervision of a qualified occupational therapist.

A qualified occupational therapist is one registered by the American Occupational Therapy Association or is a graduate of a program in such therapy approved by the Council on Medical Education of the American Medical Association in collaboration with the American Occupational Therapy Association, and is engaged in the required supervised clinical experience period prerequisite to the registration by the American Occupational Therapy Association.

An occupational therapy assistant is one who works under the supervision of a qualified occupational therapist and has successfully completed a training course approved by the American Occupational Therapy Association, and is certified by that body as a certified occupational therapy assistant.

**D. Aides to Physical, Speech, and Occupational Therapists and Other Supplementary Personnel.** The cost of the services of aides and other personnel providing supplementary services is covered when such an aide or other person is trained and supervised by appropriate professional personnel.

**205.3 Medical Social Services.**—These services must be under the direction of a physician and must be given by or under the supervision of a qualified medical or psychiatric social worker.

A qualified medical or psychiatric social worker is a graduate of a school of social work accredited by the Council on Social Work Education, and has had social work experience in a hospital, outpatient clinic, medical rehabilitation, or medical care program.

A social work assistant is one who works under the supervision of a qualified medical or psychiatric social worker, and has a baccalaureate degree, and has received or is receiving on-the-job training in medical social service tasks and assignments from the agency.

**205.4 Part-Time or Intermittent Services of a Home Health Aide.**—The services of a home health aide are directed toward the personal care of a patient and are given in accordance with physician's orders and under the supervision of a registered professional nurse, or, if appropriate, a physical, speech, or occupational therapist. The assignment of a home health aide to a particular case must be made in accordance with a plan of treatment. The specific personal care services to be provided by the home health aide must be determined by a registered professional nurse, and not by the home health aide.

The duties performed are essentially personal health care for the patient, i.e., helping the patient to bathe, get in and out of bed and exercise, retraining the patient in the necessary household skills, assisting him with medications that ordinarily are self-administered and which have been specifically ordered by a physician, and performing incidental household services which are essential to the patient's health care at home and necessary to prevent or postpone institutionalization. The discussion of "part-time or intermittent" services in § 205.1 above is also applicable to home health aides.

**205.5 Medical Supplies (Except for Drugs and Biologicals) and the Use of Medical Appliances.**—Medical supplies are items which are essential to enable the home health agency to carry out effectively in the home the kinds of care which the physician has ordered. Medical supplies include (but are not limited to) gauze, cotton, adhesive bandage, surgical dressings, catheters, surgical gloves, rubbing alcohol, irrigating solutions, intravenous fluids, and oxygen.

Medical appliances are items owned or rented by the home health agency and loaned to the patient to facilitate his treatment and rehabilitation. They include, but are not limited to, such items as bedpans,

wheelchairs, crutches, hospital beds, trapeze bars, oxygen tents, intermittent positive pressure machines, and air pressure mattresses.

Drugs and biologicals are excluded from coverage as items or services administered by home health agencies, under either hospital insurance or medical insurance. They may, in certain cases, be covered under medical insurance, when administered by a physician as a part of his professional services and are not capable of being self-administered.

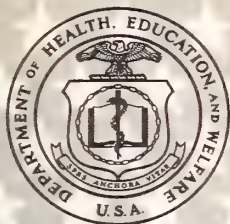
**205.6 Services of Interns and Residents.**—Home health services include the medical services of interns and residents-in-training under an approved hospital teaching program (if the agency has an affiliation with or is under common control of a hospital providing such medical services). "Approved" means approved by the Council on Medical Education of the American Medical Association, or in the case of an osteopathic hospital, the Committee on Hospitals of the Bureau of Professional Education of the American Osteopathic Association, and, in the case of an intern or resident-in-training in the field of dentistry, approved by the Council on Dental Education of the American Dental Association. Reimbursement is provided under Part B for the services other hospital interns and residents furnish to beneficiaries receiving home health services.

**205.7 Outpatient Services.**—Outpatient services include any of the items or services described above which are provided under arrangements on an outpatient basis at a hospital, extended care facility, rehabilitation center, or outpatient department affiliated with a medical school, and (1) which require equipment not readily available at the patient's place of residence or (2) which are furnished while he is at the facility to receive the services described in (1). The hospital, extended care facility, or outpatient department affiliated with a medical school must all be qualified providers of services. However, there are special provisions for the use of the facilities of rehabilitation centers (see § 200.3). The cost of transporting an individual to a facility cannot be reimbursed.

## **208. CONDITIONS FOR COVERAGE FOR HOME HEALTH SERVICES UNDER BOTH HOSPITAL AND MEDICAL INSURANCE**

**208.1 Patient Must Be Under Care Of A Physician.**—Items and services must be furnished to an individual who is under the care of a physician. This physician may be the patient's private physician; or, a physician on the staff of the home health agency; or





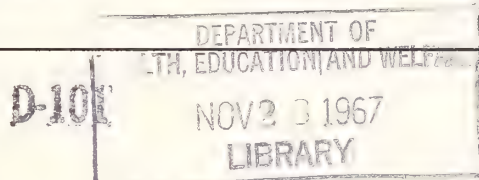
# HOME HEALTH AGENCY MANUAL REVISION

U.S. DEPARTMENT OF  
HEALTH, EDUCATION, AND WELFARE  
SOCIAL SECURITY ADMINISTRATION  
HIM-11

HEALTH INSURANCE FOR THE AGED

OCTOBER 1967

NO. 4



## New Material

	<i>Replace- ment Pages</i>	<i>Discard Pages</i>
Sec. 110.4 (Cont.)—115.2.....	5-6	5-6
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Sec. 205.1 (Cont.)—218.1.....	15-18	15-18
Chapter III.....	25-38	25-37
Chapter IV.....	39-60	39-42

This transmittal revises several sections in chapters I and II and completely revises and reorganizes chapters III and IV. Because of the great number of additions or changes, it should be reviewed carefully. The most significant substantive changes are highlighted below.

**Sec. 112.3.**—Now indicates that the 60-day period for ending a spell of illness is counted by beginning with the day of last discharge from a hospital or extended care facility. This is a change of position.

**Sec. 205.1.**—The statement on billing for a student nurse has been moved to § 405, Item 21A-G.

**Sec. 205.2.**—The statements on the qualifications of therapists and medical social workers have been removed. These are relevant to HHA participation rather than to coverage of home health services.

**Sec. 205.4.**—The description of incidental household services which may be performed by a home health aide has been expanded.

**Sec. 208.3.**—Spells out more thoroughly what is needed in a home health plan of treatment, including a description of the patient's functional limitation.

**Sec. 208.4.**—Combines information previously in this section and in § 208.6. Expands on what is meant by "confined to home."

**Sec. 210.2.**—Revised to show the requirements that psychiatric and tuberculosis hospitals must meet to satisfy the 3-day prior stay requirement for Part A home health coverage. Examples of the interrelationship between spell of illness and prior stay requirements have been expanded.

**Sec. 215.3.**—Examples now reflect the change of position in section 112.3.

**Sec. 304.**—This is a new section which discusses the Certificate of Social Insurance Award and the Temporary Notice of Eligibility as additional means of identifying the patient's health insurance entitlement status.

**Sec. 322.**—This new section identifies those situations that require a start of care notice.

**Sec. 323.**—This new section identifies those situations that do not require a start of care notice.

**Sec. 325.**—The information in this section was previously located in section 310.1. Now includes additional information on completing the start of care entries.

**Sec. 399.**—Exhibit 1 has been updated to illustrate additional Health Insurance Numbers. Exhibit 2 now shows the latest version of Form SSA-1533, Your Record of Hospital Insurance Benefits Used Under Medicare. Exhibits 5 and 6 have been added to show the Certificate of Social Insurance Award and the Temporary Notice of Eligibility.

**Sec. 400.1.**—Deleted. List of authorized signatories no longer required.

**Sec. 401.**—This new section on general billing information covers when bills should be submitted.



**Sec. 405.**—Following are some of the significant changes in instructions for completing items on Form SSA-1487.

The items that must be completed on subsequent billings have been clarified.

*Items 11 and 12.* Inpatient admissions that occur after start of care are to be shown.

*Item 13.* The “date home health plan established” entry will not change unless a new series of

Part A visits starts.

*Item 15.* The patient’s request for payment may be obtained on the agency’s own record.

*Item 18.* This item no longer needs to be completed.

*Item 19.* Provides guides for checking the “Discharged” and “Visits Exhausted” blocks.

*Item 20.* Tells when item must be completed.

*Item 21.* Breaks out the lettered subsections and gives instructions for completing each. Makes provision for identifying outpatient visit information.

**Sec. 410.**—Billing procedures when patient transfers from Part A to Part B.

**Sec. 411.**—Billing procedures when patient transfers from Part B to Part A.

**Sec. 412.**—Describes the effect on billing when a new spell of illness begins.

**Sec. 413.**—Describes billing procedures if more than one agency is rendering services at the same time.

**Sec. 415.**—Describes billing procedures when patient transfers to another agency but the same plan of treatment is continued.

**Sec. 420.**—Describes billing procedures for rental of durable medical equipment. Since rental of equipment is only covered if no plan of treatment is in effect, special procedures must be followed in billing.

**Sec. 425.**—Describes billing procedures when home health services are suspended or terminated and then reinstated.

**Sec. 430.**—Explains how and when a billing form must be submitted if no payment will be made.

**Sec. 440.**—The agency should not include in a Part B billing a period that overlaps 2 calendar years.

**Sec. 445.**—Provides the procedure for submitting corrected bills.

**Sec. 450.**—Provides examples of billing forms completed to reflect many different situations.

THOMAS M. TIERNEY, *Director*  
*Bureau of Health Insurance*

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Revision transmittal sheets should be filed at the end of the manual as a record of receipt.

*Chapter IV is revised so extensively that no brackets have been entered to indicate changed material. The entire chapter should be reviewed.*

surance and also under supplementary medical insurance. (For a complete discussion of these services, see chapter II.)

## **112. HOSPITAL INSURANCE DEFINITIONS RELATING TO PART A HOME HEALTH SERVICES**

**112.1 Hospital.**—A hospital is an institution which—

A. is primarily engaged in providing, by or under the supervision of physicians, to inpatients—

1. diagnostic and therapeutic services for medical diagnosis, treatment, and care of injured, disabled, or sick persons, or

2. rehabilitation services for the rehabilitation of injured, disabled, or sick persons.

B. maintains clinical records on all patients;

C. has bylaws in effect concerning its staff of physicians;

D. has a requirement that every patient must be under the care of a physician;

E. provides 24-hour nursing service by or supervised by a registered professional nurse and has a licensed practical nurse or registered professional nurse on duty at all times;

F. has in effect a hospital utilization review plan;

G. is licensed or is approved by the State or local licensing agency as meeting the standards established for such licensing; and

H. meets other health and safety requirements of the Secretary of the Department of Health, Education, and Welfare. (These additional requirements may not be higher than comparable ones prescribed for accreditation by the Joint Commission on Accreditation of Hospitals with certain exceptions specified in the law.)

I. is not primarily for the care and treatment of mental diseases or tuberculosis.

**112.2 Extended Care Facility.**—An extended care facility is one which provides skilled nursing care and related services for patients who require medical or nursing care; or rehabilitation services for injured, disabled, or sick persons. It may be either a separate institution (such as a nursing home) or a part of an institution (such as a convalescent wing of a hospital), licensed or approved for licensing under State or local law, and meet the health and safety conditions prescribed by the Secretary of the Department of Health, Education, and Welfare. The extended care facility must have a written transfer agreement with one or more participating hospitals providing for the transfer of patients between the hospital and the facility and for the interchange of medical and other information. If an otherwise qualified facility has failed in an attempt, in good faith, to enter into such an agreement, the agreement requirement may be waived by the State agency. A facility primarily for the care and treatment of mental disease or tuberculosis may not qualify

as a participating extended care facility in the health insurance program.

Qualified facilities must enter into the required agreement with the Secretary to participate as providers of services in the health insurance program.

A patient can meet the prior stay requirement for "posthospital" home health services (see chapter II) by a covered stay in a participating extended care facility. See § 110.3 for the conditions of a covered stay.

**112.3 Spell of Illness Defined.**—A spell of illness is a period of consecutive days that **begins** with the first day (not included in a previous spell of illness) on which a patient is furnished inpatient hospital or extended care services by a qualified provider in a month for which the patient is entitled to hospital insurance benefits. A qualified hospital (including a psychiatric or tuberculosis hospital) or extended care facility is one that has been certified as meeting all the requirements of the definition of such an institution. A hospital which meets the requirements in the definition of a hospital except for F and H in § 112.1 is also a qualified hospital for purposes of beginning a spell of illness when such hospital furnishes the patient covered *inpatient emergency services*. **Thus, generally, the spell of illness begins when covered inpatient services are initially furnished to an entitled individual.**

The spell of illness **ends** with the close of a period of 60 consecutive days during which the patient was neither an inpatient of a hospital nor an inpatient of an extended care facility. In determining the 60-consecutive-day period, the day of discharge should be counted. **It is important to note that for purposes of continuing a spell of illness, the hospital or extended care facility in which the stay occurs need not meet all of the requirements that are necessary for starting a spell of illness.**

Inpatient services will prolong the beneficiary's spell of illness if the **hospital** is primarily engaged in providing, by or under the supervision of physician(s), to inpatients (1) diagnostic and therapeutic services for medical diagnosis, treatment, and care of injured, disabled, or sick persons, or rehabilitation services for injured, disabled, or sick persons; **or** (2) psychiatric services for the diagnosis and treatment of mentally ill persons; **or** (3) medical services for the diagnosis and treatment of tuberculosis.

Similarly, inpatient services in an **extended care facility** will prolong a beneficiary's spell of illness if the facility (including one primarily for the care and treatment of mental diseases or tuberculosis) meets at least the requirement that it is primarily engaged in providing to inpatients skilled nursing care and related services for patients who require medical or nursing care, or rehabilitation services for injured, disabled, or sick persons.



An individual may be discharged from and readmitted to a hospital or extended care facility several times during a spell of illness and still be in the same spell if 60 days have not elapsed between discharge and readmission. The stay need not be for related physical or mental conditions.

As long as a person continues to be entitled to hospital insurance, there is no limit to the number of spells of illness he may have.

**Example 1:** X was born August 9, 1902. On July 28, 1967, X entered a participating general hospital. After he had been in the hospital for 2 weeks X was discharged on August 11, 1967. On his doctor's orders X entered a participating nursing home on August 15, 1967, and remained there until his discharge on October 27, 1967. He had no further inpatient stays in 1967. X's spell of illness began on August 1, 1967, the first day of the month he attained age 65 and was entitled to hospital insurance. The spell of illness ended December 25, 1967, the end of the 60-day period beginning with the day of last discharge.

**Example 2:** Y, over age 65, entered a participating general hospital on July 28, 1968, for treatment of a heart condition. He was discharged on August 11, 1968. On August 20, 1968, Y entered a **nonparticipating nursing home**, which provided primarily skilled nursing care and related services. Y remained in this facility until his discharge on October 27, 1968. On December 25, 1968, Y was again admitted to a participating hospital because of injuries suffered in an accident. He was discharged on January 13, 1969, and had no further inpatient stays in 1969. Y's spell of illness began on July 28, 1968. His stay in the nursing home began less than 60 days after his hospital discharge and the spell was continued even though the stay was not covered. The subsequent hospital stay began less than 60 days after the nursing home discharge and continued the spell of illness although the condition treated was unrelated to his prior stays. The spell ended on March 13, 1969, the end of the 60-day period beginning with the day of last discharge.

## 115. SUPPLEMENTARY MEDICAL INSURANCE—A BRIEF DESCRIPTION

**115.1 Benefits.**—The voluntary medical insurance plan is designed to supplement the basic hospital insurance coverage. It provides coverage effective July 1, 1966, for (a) home health services (a full discussion of the coverage under this phase of the program is contained in chapter II), and (b) medical and other health services.

Medical and other health services include:

A. Physicians' services (see definition of "physician" below) including surgery, consultation, and home, office, and institutional calls.

Regardless of the actual expenses for physician serv-

ices incurred in the treatment of mental, psychoneurotic, or personality disorders of persons who are not inpatients of hospitals, the amount of such expenses that can be counted in a calendar year is limited to the lesser of \$312.50 or 62.5 percent of the actual expenses.

**Physician** means a doctor of medicine or osteopathy (including osteopathic practitioner) legally authorized to practice by a State in which he performs the function. A doctor of dental surgery or dental medicine having State authorization to practice is also defined as a physician but only with respect to surgery related to the jaw or any structure contiguous to the jaw, or the reduction of any fracture of the jaw or any facial bone. The services performed by physicians within these definitions are subject to any limitations imposed by the State on the scope of practice.

B. Services and supplies (including drugs and biologicals which cannot be self-administered) incident to physicians' professional services and of kinds commonly furnished by a physician in his office and which are commonly rendered without charge or included in his bill. The services include hospital services (including drugs and biologicals which cannot be self-administered) incident to physicians' services rendered to outpatients.

C. Diagnostic X-ray, laboratory, and other diagnostic tests.

D. X-ray, radium, and radioactive isotope therapy (including material and services of technicians).

E. Surgical dressings, and splints, casts, and other devices used for reduction of fractures and dislocations.

F. Rental (for use in the patient's residence, including an institution used as his home) of such durable medical equipment as iron lungs, oxygen tents, wheelchairs, and special beds.

G. Ambulance service, where the use of other transportation is contraindicated by the patient's condition. (Transportation service from place of residence to a facility to receive home health services on an outpatient basis is excluded.)

H. Prosthetic devices (other than dental) replacing all or part of an internal body organ, including replacement of such devices.

I. Leg, arm, back, and neck braces, and artificial legs, arms, and eyes, including replacements if required because of a change in physical condition.

**115.2 Basis for Payment.**—Payment, based on **reasonable charges**, may be made to or on behalf of individuals covered by medical insurance for services of physicians and other nonprovider services furnished under the plan. In determining the reasonableness of charges the carrier takes into consideration the customary charges of the physician (or other person rendering the service) as well as the prevailing charges in the locality generally made for similar services. A



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the supervisor accompanies the student on a visit.)

**C. Part-Time or Intermittent Care.**—Part-time or intermittent nursing care is usually service for a few hours a day several times a week. Occasionally, service for a full day may be provided for a short period when, because of unusual circumstances, neither the alternative of part-time care nor hospitalization is feasible.

**205.2 Physical, Speech, and Occupational Therapy.**—Physical, speech, and occupational therapy furnished by the home health agency is covered when provided in accordance with a physician's orders and by or under the supervision of a qualified therapist.

The cost of the services of aides and other personnel providing supplementary services is covered when such an aide or other person is trained and supervised by appropriate professional personnel.

**205.3 Medical Social Services.**—These services must be under the direction of a physician and must be given by or under the supervision of a qualified medical or psychiatric social worker.

**205.4 Part-Time or Intermittent Services of a Home Health Aide.**—The services of a home health aide are directed toward the personal care of a patient and are given in accordance with physician's orders and under the supervision of a registered professional nurse, or, if appropriate, a physical, speech, or occupational therapist. The assignment of a home health aide to a particular case must be made in accordance with a plan of treatment. The specific personal care services to be provided by the home health aide must be determined by a registered professional nurse, and not by the home health aide.

Personal care duties which may be performed by a home health aide are essentially those which would be performed by a nurse's aide in an institution. These include assistance in the activities of daily living, e.g., helping the patient to bathe, to get in and out of bed, to care for his hair and teeth, to exercise, and to take medications specifically ordered by a physician which are ordinarily self-administered, and retraining the

disabled patient in necessary household skills. The home health aide may also perform certain incidental household services intimately related to the health care of the patient which are similar to those performed by nurses' aides in an institution. These services include keeping the room of a bedridden patient a safe environment (e.g., changing the bed, straightening the room to assure that the beneficiary can reach necessary supplies or medications, etc.), the preparation of food for the patient, and the washing of the dishes used. If a patient has a contagious disease, such services may include washing or sterilizing utensils and dishes used by the patient. However, general housekeeping duties (e.g., cleaning the house, shopping for groceries, doing the laundry, and caring for the family) are **not** reimbursable. The discussion of part-time or intermittent services in § 205.1 is also applicable to home health aides.

**205.5 Medical Supplies (Except for Drugs and Biologicals) and the Use of Medical Appliances.**—Medical supplies are items which are essential to enable the home health agency to carry out effectively in the home the kinds of care which the physician has ordered. Medical supplies include (but are not limited to) gauze, cotton, adhesive bandage, surgical dressings, catheters, surgical gloves, rubbing alcohol, irrigating solutions, intravenous fluids, and oxygen.

Medical appliances are items owned or rented by the home health agency and loaned to the patient to facilitate his treatment and rehabilitation. They include, but are not limited to, such items as bedpans, wheelchairs, crutches, hospital beds, trapeze bars, oxygen tents, intermittent positive pressure machines, and air pressure mattresses.

Drugs and biologicals **are excluded** from coverage as items or services administered by home health agencies, under either hospital insurance or medical insurance. They may, in certain cases, be covered under medical insurance, when administered by a physician as a part of his professional services and are not capable of being self-administered.



**205.6 Services of Interns and Residents.—**

Home health services include the medical services of interns and residents-in-training under an approved hospital teaching program (if the agency has an affiliation with or is under common control of a hospital providing such medical services). "Approved" means approved by the Council on Medical Education of the American Medical Association, or in the case of an osteopathic hospital, the Committee on Hospitals of the Bureau of Professional Education of the American Osteopathic Association, and, in the case of an intern or resident-in-training in the field of dentistry, approved by the Council on Dental Education of the American Dental Association. Reimbursement is provided under Part B for the services other hospital interns and residents furnish to beneficiaries receiving home health services.

**205.7 Outpatient Services.—**Outpatient services include any of the items or services described above which are provided under arrangements on an outpatient basis at a hospital, extended care facility, re-

habilitation center, or outpatient department affiliated with a medical school, and (1) which require equipment which cannot readily be made available at the patient's place of residence or (2) which are furnished while he is at the facility to receive the services described in (1). The hospital, extended care facility, or outpatient department affiliated with a medical school must all be qualified providers of services. However, there are special provisions for the use of the facilities of rehabilitation centers (see § 200.3). The cost of transporting an individual to a facility cannot be reimbursed as a home health service.

**208. CONDITIONS FOR COVERAGE FOR HOME HEALTH SERVICES UNDER BOTH HOSPITAL AND MEDICAL INSURANCE**

**208.1 Patient Must Be Under Care Of A Physician.—**Items and services must be furnished to an individual who is under the care of a physician. This physician may be the patient's private physician; **or**, a physician on the staff of the home health agency; **or**

a physician working under an arrangement with the institution which is the patient's residence; or if the agency is hospital-based, a physician on the hospital or agency staff. The attending physician establishes the plan of treatment and also certifies to the necessity for home health services.

**208.2 Services Furnished by Agency.**—Items and services must be furnished by a participating home health agency or by others under arrangements made by the agency. (See § 200.2 for definition of "under arrangements.")

**208.3 Services Furnished Under a Plan.**—Items and services must be furnished under a plan established and periodically reviewed by a physician and which relates the items and services to the patient's condition. A plan must be reduced to writing by the physician and be made available to the home health agency which has accepted the patient as a client. (See § 210.3 for coverage of Part A services rendered before the plan is reduced to writing.) Part B home health services furnished before the plan is reduced to writing are covered if authorized by a physician. However, the plan is to be reduced to writing prior to the submission of the bill. The plan should specify the types of services required and should, as far as possible, provide a long-range forecast of likely changes in the patient's condition. It should include the diagnosis and a description of the patient's functional limitation resulting from the illness or injury, the type and frequency of nursing services needed, drugs and medications, special diets, activities permitted, rehabilitation and therapy services, medical social services, home health aide services, and the medical supplies and appliances necessary.

The plan is signed by the attending physician and incorporated into the agency's permanent record for the patient. Any changes should be made in writing and signed by the physician or by a registered professional nurse on the staff of the agency pursuant to the physician's oral orders. All changes in orders for dangerous drugs and narcotics must be signed by the physician.

The plan must be reviewed by the attending physician, in consultation with agency professional personnel, at such intervals as the severity of the patient's illness requires but at least every 2 months. Each review of a patient's plan should contain the initials of the physician and show the date performed. The agency's record need not be forwarded to the inter-

mediary for review but will be retained in the agency's file.

When an individual has coverage under both Part A and Part B, home health plans under both parts should not operate concurrently. For example, a plan of treatment is established after hospitalization for a condition for which the patient was hospitalized, and the patient later requires home health services for a condition unrelated to the previous hospitalization but while the original plan of treatment is still in effect. The original plan of treatment should be modified to take into account the required home health services for the condition not related to previous hospitalization. Otherwise, there would be administrative difficulties in counting home health visits, particularly if two home health agencies become involved. Of course, if the patient does not have Part B coverage, the original plan of treatment cannot be modified to provide home health services not related to prior hospitalization.

When benefits under hospital insurance have been exhausted and a change to benefits under medical insurance is made, it is not necessary for the physician to change the plan of treatment.

**208.4 Patient Confined to His Home.**—In order for a beneficiary to be eligible to receive covered home health services under both Part A and Part B, the law requires that a physician certify in all cases that the beneficiary is confined to his home (see § 240.1). An individual does not have to be bedridden to be considered as confined to his home. However, he must have a functional limitation due to an illness or injury which restricts his ability to leave his place of residence. In fact, the condition of these patients should be such that leaving their homes would require a considerable and taxing effort and would be possible only with the aid of supportive devices such as crutches, canes, wheelchairs, and walkers, the use of special transportation, or the help of others. The aged person who does not often travel from his home because of feebleness and insecurity brought on by advanced age would not be considered confined to his home for purposes of receiving home health services unless he has a physical limitation due to an illness or injury.

For example, an individual paralyzed from a stroke who is confined to a wheelchair or who requires the use of supportive devices would obviously be considered as confined to his home. On the other hand, a person whose impairment affects only the upper extremities and who is able to ambulate without difficulty would



not be considered as confined to his home. A patient who requires speech therapy services but does not require physical therapy or nursing services, must, in order to be considered as confined to his home, have a functional limitation in addition to a speech defect which would restrict his ability to leave his home. Thus, a patient who has undergone a laryngectomy yet is not in need of nursing services and has no other functional limitation would not be considered as confined to his home. However, a patient who is paralyzed by a stroke and unresponsive to physical therapy but who can benefit from speech therapy would be considered as confined to his home.

Although a patient must be confined to his home to be eligible for covered home health services, some services cannot be provided at the patient's residence because equipment is required which cannot be made available there. If the services required by an individual involve the use of such equipment, the home health agency may make arrangements with a hospital, extended care facility, or a rehabilitation center to provide these services on an outpatient basis (see §§ 200.2 and 205.7). However, even in these situations the patient must be considered as confined to his home. It may be expected, therefore, that a homebound patient will require the use of supportive devices, special transportation or the help of others to travel to the appropriate outpatient facility. Absent evidence to the contrary, a home health patient who makes one such outpatient trip a week or less will be considered as being confined to his home. In those cases in which treatments are required more than once a week, the agency will be requested to furnish the intermediary with documentation of the functional limitation of the beneficiary.

**208.5 Patient's Place of Residence.**—A patient's residence is wherever he makes his home. This may be his own dwelling, an apartment, a relative's home, a home for the aged, or some other type of institution. However, an institution may not be considered a patient's residence if it:

(a) Meets at least the basic requirement in the definition of a hospital, (§ 112.1), i.e., it is primarily engaged in providing by or under the supervision of physicians, to inpatients, diagnostic and therapeutic services for medical diagnosis, treatment, and care of injured, disabled, or sick persons, or rehabilitation services for the rehabilitation of injured, disabled, or sick persons, or

(b) Meets at least the basic requirement in the definition of an extended care facility, (§ 112.2), i.e., it

is primarily engaged in providing to inpatients skilled nursing care and related services for patients who require medical or nursing care, or rehabilitation services for the rehabilitation of injured, disabled, or sick persons. If a patient is transferred from a participating extended care facility to a nonparticipating part of the facility which he uses as his home, the part will not be considered the patient's residence if it meets this requirement.

Thus, if an individual is a patient in an institution or distinct part of an institution which provides the services described in (a) or (b) above, he is not entitled to have payment made for home health services under either Part A or Part B since such an institution may not be considered his residence.

When a patient remains in a participating extended care facility following his discharge from active care, the facility may not be considered his residence for purposes of home health coverage.

## **210. SPECIAL CONDITIONS FOR COVERAGE OF HOME HEALTH SERVICES UNDER HOSPITAL INSURANCE (PART A)**

In addition to the conditions listed in § 208, the following conditions must be met for coverage under hospital insurance.

**210.1 Effect of Spell of Illness on Coverage.**—Hospital insurance coverage extends only to home health visits (100 or less) furnished after the beginning of one spell of illness and before the beginning of the next.

The controlling event is the **beginning** of the spell of illness. Thus, the spell of illness requirement is satisfied if, when the home health services are furnished, the patient is either in a spell of illness, or has ended a spell of illness and not begun a new one. A series of visits ends with the beginning of a new spell of illness. (See § 112.3 for the definition of spell of illness and the examples in § 210.2 for the interrelationship of the spell of illness and the prior stay requirements.)

**210.2 Prior Inpatient Stay.**—In addition to the spell of illness requirement, the law further specifies that a patient is entitled to these home health visits under hospital insurance in the year following his most recent discharge from a covered stay of any duration in an extended care facility or from a stay of at least 3 consecutive days in § 112.1 except requirements F, T, and I (the



atric hospital, or tuberculosis hospital, or (2) a participating distinct part of a psychiatric or tuberculosis hospital, or (3) a nonparticipating hospital, psychiatric hospital, or tuberculosis hospital which meets at least the conditions of participation for hospitals described in § 112.1 except requirements F, H, and I (the special requirements for tuberculosis and psychiatric hospitals need not be met).

In determining whether the 3-day period of hospitalization has been met, the day of admission, **but not the day of discharge**, is counted as a hospital inpatient day.

The discharge from the hospital which is required to qualify home health services for payment under hospital insurance must have occurred after June 30, 1966, and in a month in which the patient has attained age 65. Since the extended care facility discharge must be from a covered stay, it must have occurred after December 31, 1966. There must be an actual discharge of the patient from the hospital or extended care facility to his residence. See § 208.5 for conditions under which an institution may not be considered the patient's residence.

**Note:** Ordinarily the spell of illness and prior inpatient stay requirements will be met by the same 3-day stay in a participating hospital. However, there are special situations where multiple inpatient stays combine to satisfy both requirements.

**Example 1:** A covered 1-day hospital stay began a spell of illness but did not satisfy the prior stay requirement. A subsequent noncovered stay of at least 3 days' duration in a nonparticipating hospital described above could satisfy the prior inpatient stay requirement even though it would not start a spell of illness. The 3-day stay may occur, for example, within 60 days after the 1-day hospital stay, i.e., during the spell of illness, or more than 60 days after the 1-day hospital stay, i.e., after the spell of illness ended.

**Example 2:** A noncovered 3-day hospital stay in a nonparticipating hospital described above satisfies the prior stay requirement. A subsequent 1-day stay in a participating hospital starts the spell of illness.

See § 210.3 for time limit on plan establishment following discharge from prior stay.

The following are examples of situations where a single inpatient stay satisfies both requirements.

**Example 3:** A noncovered 3-day hospital stay in a nonparticipating hospital described above, is followed within 14 days by a 1-day covered extended

care facility stay. In this case, the 3-day hospital stay satisfies the prior stay requirement for coverage of the ECF stay (§ 110.3). The 1-day ECF stay begins the spell of illness and satisfies the prior stay requirement for subsequent home health services.

**Example 4:** A noncovered 3-day stay in a qualified but nonparticipating hospital (§ 112.3) satisfies both the spell of illness and prior stay requirements.

See additional examples in § 215.3.

**210.3 Fourteen-Day Limit on Plan Establishment.**—The plan for home health services (§ 208.3) must be established within 14 days after the patient's discharge from the qualifying prior inpatient stay. In determining the 14-day period, the day of discharge is **not** counted in the 14 days. For example, a patient's plan is established within 14 days if he was discharged from a hospital on August 1 and his plan was established on August 15.

In some cases services are furnished after discharge from the hospital or extended care facility and before the plan has been reduced to writing. Payment under Part A may be made for such services if authorized by a physician, provided the plan is reduced to writing within 14 days of the patient's discharge.

**210.4 Related Illness or Impairment.**—In order for home health services to be covered under hospital insurance, a doctor must certify that the patient needs intermittent nursing care or physical or speech therapy for any condition for which he was receiving inpatient hospital or extended care services.

**210.5 Transfer of Patient.**—If it becomes necessary for the patient to transfer to a different physician or home health agency (in a different locality) after the timely establishment of the required physician's plan, the original plan may be continued in the new locality if:

A. There is a referral by the patient's physician in the old locality of both the patient and the plan to a physician in the new locality.

B. The patient's physician in the new locality accepts the original plan of treatment and assumes the responsibility of conducting the required periodic reviews of the plan. The plan could be modified from time to time as determined necessary by the patient's physician in the new locality.

C. A participating home health agency in the new locality accepts the patient.

The number of posthospital home health visits already used in the old locality in the (applicable) year

would be taken into account in determining when the limit of 100 visits under the hospital plan is reached.

**Example:** A health insurance beneficiary has received 40 home health visits under Part A when it is decided that his overall recovery would be hastened if he moved to a relative's home in a city 100 miles away. However, the physician who established and is reviewing his home health plan recommends that the physical therapy treatments he has been receiving be continued. A physician in the distant city concurs and agrees to take responsibility for continuance of the plan. When the patient moves, the plan is submitted to a home health agency in that city and services continue as before. The patient is entitled to the remaining 60 home health visits in the applicable year under Part A at his new residence.

## **212. SPECIAL CONDITIONS FOR COVERAGE OF HOME HEALTH SERVICES UNDER SUPPLEMENTARY MEDICAL INSURANCE (PART B)**

**212.1 Non-Eligibility Under Hospital Insurance.**—For home health services to be covered under supplementary medical insurance, the patient must be currently enrolled in the medical insurance plan and where the home health services to be provided are covered under hospital insurance, not be eligible to receive such services under hospital insurance. Where a patient is eligible for home health services which are covered under both programs, the services are chargeable under hospital insurance. When the benefits payable under hospital insurance are exhausted, he may then utilize the benefits available under the supplementary medical insurance program. A plan covering services under the medical insurance program must be established by the physician, and must be reduced to writing before the agency bills for the services.

Prior inpatient care in a hospital or extended care facility is **not** required for coverage of home health services under the supplementary medical insurance plan.

**212.2 Change to Medical Insurance Home Health Services on Change of Residence.**—A patient who changes residence before exhausting his 100 home health visits under hospital insurance can receive further home health services **only** under the medical insurance program if there is no further eligibility for home health services under the hospital insurance plan. This might occur, for example, in the following situations:

A. The physician in the old locality terminates the posthospital home health plan, or

B. There is no physician in the new locality who agrees to accept both the patient and the plan, e.g., the new physician wants to establish an entirely new plan.

For coverage under medical insurance in these circumstances, the new physician must establish a new plan.

See § 210.5 for conditions under which home health services under hospital insurance may continue in the new locality.

## **215. DURATION OF HOME HEALTH SERVICES**

**215.1 Duration of Home Health Services Under Hospital Insurance.**—Under hospital insurance the patient is entitled to up to 100 visits in the 1-year period after the **most recent discharge** from a qualifying inpatient stay (§ 210.2) and before a new spell of illness begins (§ 210.1).

If before a series of home health visits is completed, a patient receives inpatient services which start a new spell of illness, the series of visits is terminated. Both the “prior inpatient stay” (§ 210.2) and “timely establishment of plan” (§ 210.3) requirements must be met in the new spell of illness to provide coverage for a new series of home health visits.

If, during the same spell of illness, the home health patient returns to a hospital or extended care facility for a stay which meets the prior-stay requirement, a new 1-year period for his Part A visits is established dating from his latest discharge. The total number of visits available before the next spell of illness begins remains unchanged.

In rare cases a home health patient may return to a hospital for a stay which satisfies the prior-stay requirement but does not begin a new spell of illness, i.e., a 3-day noncovered stay in a nonparticipating hospital which meets all the conditions of participation except for the utilization review and health and safety requirements (see § 112.1). In this situation a new 1-year period begins with the discharge and the number of visits remains unchanged.

The end of the year for hospital insurance purposes is determined as follows:

Count 365 days (366 when February 29 is included) beginning with the later of the following:

a. The date of discharge after June 30, 1966, from a 3-day stay in any hospital, or



b. The date of discharge after December 31, 1966, from an extended care facility stay for which post-hospital extended care benefits were payable on the patient's behalf.

**215.2 Duration of Home Health Services Under Supplementary Medical Insurance.**—Under supplementary medical insurance a patient is entitled to 100 visits in a calendar year. Entitlement to visits under supplementary medical insurance is related to the calendar year and is unaffected by the patient's spell(s) of illness. If entitled to services under both hospital insurance and supplementary medical insurance, the visits must first be charged against the hospital insurance.

The end of the year under medical insurance is December 31.

**215.3 Examples of Duration of Services Under Hospital and Medical Insurance.**

*Example 1:* Jones is hospitalized on February 10 and discharged on March 15, 1967; he has no other hospital or extended care facility stay in 1967 or 1968. He has 100 home health visits beginning the latter part of March and ending on February 20, 1968. All 100 visits are paid for under hospital insurance since the 1-year period runs from March 15, 1967, the date of the hospital discharge, to March 14, 1968. Although Jones' spell of illness ended on May 13, 1967, the end of the 60-day period beginning with the day of the hospital discharge, home health eligibility was unaffected since a new spell of illness did not begin subsequently.

*Example 2:* Robinson was an inpatient in a hospital four times during the same spell of illness, i.e., there was no period of 60 consecutive days during which he was not hospitalized. He was discharged from the hospital, which meets the requirements to qualify subsequent home health services for payment under hospital insurance, on March 15, 1967, May 13, 1967, July 12, 1967, and September 9, 1967. Each hospital stay was for at least 3 consecutive days except the last one. He had home health visits beginning with May 23, 1967, based on a plan established after his hospital discharge of May 13. The 1-year period for home health services under hospital insurance began May 13, 1967, the date of his most recent discharge (in relation to the first home health visit in the spell of illness) from a hospital after a stay of 3 days; it can end no later than July 12, 1968, 1 year after the latest discharge from a hospital stay of at least 3 con-

secutive days. Thus, in some situations, the "1-year period" during which an individual may have up to 100 home health visits may in fact exceed a year overall.

*Example 3:* Smith is hospitalized on February 10 and discharged on March 15. He reenters the hospital on July 4. He had 30 home health visits between March 15 and July 4. Since he had been out of the hospital for more than 60 days after his discharge on March 15, a new spell of illness began on July 4, when he reentered the hospital. Therefore, he is not entitled to any additional home health visits under hospital insurance based on his February–March hospital stay. However, an additional 100 home health visits under hospital insurance may begin based on his hospitalization beginning July 4, if he is confined for at least 3 days. If it is for less than 3 days, he will not qualify for home health visits under hospital insurance in the new spell of illness. However, if he is enrolled in the supplementary medical insurance program he is entitled to an additional 100 visits under Part B through December 31, subject to the deductible provisions.

*Example 4:* Brown is discharged from a hospital on February 15, 1967, after a 3-day stay. He begins receiving home health visits on February 18, 1967. He has until February 14, 1968, to use his 100 visits under hospital insurance. In July, however, he receives his 100th visit, exhausting the number of visits to which he is entitled under hospital insurance. Coverage of his home health visits may continue unbroken, if he is enrolled under supplementary medical insurance. In that event, he may receive an additional 100 visits under medical insurance through December. In January 1968, he becomes entitled to an additional 100 visits under supplementary medical insurance for the calendar year of 1968.

## **218. COUNTING VISITS UNDER THE HOSPITAL AND MEDICAL PLANS**

The number of visits are counted in the same manner under both the hospital plan and medical plan.

**218.1 Visit Defined.**—A visit is a personal contact in the place of residence of a patient made for the purpose of providing a covered service by a health worker on the staff of the home health agency or by others under contract or arrangement with the home health agency; or a visit by a patient on an outpatient basis to a hospital, extended care facility, or rehabilitation

(Continued on page 19)





### Chapter III

## START OF CARE PROCEDURES

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## Chapter III

### START OF CARE PROCEDURES

#### 300. SUMMARY OF START OF CARE PROCEDURES

The purpose of this section is to give a brief outline of routine handling of admissions. Detailed instructions on procedures as well as descriptions of special situations are given in subsequent sections.

The first step in preparing the start of care notice for home health services is to ask the patient for his health insurance card. **It is very important that the claim number on this card be accurately recorded on the start of care notice since the case cannot be processed if the number is missing or incorrect.**

If you cannot obtain the health insurance claim number from the patient, you should get in touch with the Social Security Administration district office for help in securing a claim number for the patient.

The second step is to record information about the patient's prior hospital or extended care facility stays, or any prior home health services furnished, and the date the present home health plan was established. This information will help the intermediary to determine the patient's eligibility. Your intermediary (or the Social Security Administration, if you are dealing directly with the Government) will make any necessary verification of prior stays.

The third step is to fill in the other items on the start of care notice, have the patient sign the form, and send the information to your intermediary, or the social security district office if you deal directly.

Your intermediary will check the Social Security Administration central record, verify a prior stay if necessary, then send you a reply which will show whether the patient is eligible under hospital or medical insurance, the number of visits remaining, and deductible status. With this information you will be able to prepare your billing form.

#### 302. HEALTH INSURANCE CARD

The Social Security Administration maintains in Baltimore, Maryland, the records of all persons entitled to health insurance. After entitlement is established

each beneficiary is issued a health insurance card by the central office of the Social Security Administration (or in some cases by the Railroad Retirement Board) for use in obtaining hospital insurance benefits, medical insurance benefits, or both. The health insurance claim number on the card is essential in locating the patient's record when a claim for benefit payment is made. **No start of care notice or billing form should be forwarded without the correct claim number.** Exhibit 1 of this chapter shows the health insurance cards and briefly explains the numbering system as an aid in recognizing valid numbers.

The home health agency should ask each patient who gives his age as 65 or older for his health insurance card to determine his health insurance entitlement status and obtain the correct health insurance claim number. If a patient is within 3 months of age 65 and has not yet applied for health insurance entitlement, it will be helpful if he, or someone on his behalf, is advised to contact the social security district office. The home health agency may wish to arrange with the district office to bring such cases routinely to the attention of the district office.

A health insurance card is acceptable without a signature. However, the patient should be asked to sign the card if he has not already done so.

#### 304. CERTIFICATE OF SOCIAL INSURANCE AWARD AND TEMPORARY NOTICE OF ELIGIBILITY

An individual who has not yet received his health insurance card may present one of the following to indicate his health insurance entitlement status.

a. **Certificate of Social Insurance Award.**—Health insurance beneficiaries receive a Certificate of Social Insurance Award (see § 399, Exhibit 5) showing the health insurance claim number, dates of entitlement to Part A and Part B, and containing the following statement:

"This notice may be used if medicare services are needed before you receive your health insurance card."

b. **Temporary Notice of Eligibility.**—When a person 65 years or older needs immediate medical serv-

ices, the social security district office may issue a Temporary Notice of Eligibility (see § 399, Exhibit 6) before a Certificate of Social Insurance Award or health insurance card is issued.

The patient's name and health insurance claim number shown on these notices should be entered on the start of care notice. The intermediary will use this information to check the Social Security Administration central record and to reply to the agency about the patient's eligibility and deductible status.

### 306. NOTICE OF HOSPITAL (OR MEDICAL) INSURANCE UTILIZATION OR EXPLANATION OF BENEFITS

If the patient cannot furnish his health insurance card, he may have a health insurance utilization form which shows his claim number. Form SSA-1533, Your Record of Hospital Insurance Benefits Used Under Medicare (see Exhibit 2), is mailed to a beneficiary from the Social Security Administration in Baltimore shortly after **Part A** inpatient hospital, extended care, or **home health** benefits have been paid on his behalf. Form SSA-1533A, Notice of Medical Insurance Utilization (see Exhibit 3), is mailed to a beneficiary by SSA after payment of **Part B home health** benefits. An Explanation of Benefits is sent to a beneficiary by the Part B intermediary after payment of a supplementary medical insurance claim. The Part A intermediary sends the beneficiary a utilization notice after payment on his behalf for outpatient hospital services. These forms, if current, may indicate to the home health agency the patient's remaining eligibility under hospital or medical insurance, recent hospitalization, or deductible status under medical insurance. **However, a start of care notice must always be sent when home health services start regardless of the currency of any of these forms.**

### 310. CONTACTS WITH THE SSA DISTRICT OFFICE TO OBTAIN HEALTH INSURANCE CLAIM NUMBERS

When a patient cannot furnish the health insurance claim number, it will be requested from the SSA district office. Ordinarily, the social security district office will have arranged with the home health agency for handling these requests. If it has not, the home health agency should get in touch with the nearest SSA district office to make such arrangements. Apart from assisting in determining correct claim numbers, the district office can help a beneficiary to replace a lost health insurance card.

## 312. INFORMATION REQUIRED BY SSA DISTRICT OFFICE

If the patient's social security account number is available, the district office will usually require no additional information to locate the claim number or determine that the patient has not established health insurance entitlement.

If the patient has ever been employed or self-employed, or sought employment, or filed Federal Income Tax returns, he should have a social security card. This card contains his social security account number which consists of 9 digits, 000-00-0000, but does not have the letter prefix or suffix which distinguishes the health insurance claim number. (See Exhibit 1.)

A social security account number is **not** sufficient for processing a claim.

If the account number is not available, the following information should be furnished.

a. The patient's name and statement as to whether or not he ever applied for social security monthly benefits, railroad retirement benefits, or for hospital insurance benefits;

b. If the patient says he applied, the name of the person on whose social security account the application was based, e.g., his own account or the account of a husband or a wife;

c. The patient's father's full name, mother's maiden name, and the patient's date and place of birth;

d. Patient's address.

If the home health agency cannot give all the identifying information required from the beneficiary, it should furnish as much as it has to the SSA district office.

## 314. THE SSA DISTRICT OFFICE REPLY

The SSA district office will furnish the health insurance claim number as soon as possible. If the claim number is not available, it will inform the home health agency of the action it is taking, i.e., that a claim number has been requested from SSA central records, that it is developing an application, or that an application is pending.

If an application for health insurance benefits is taken as a result of the request to the district office for a claim number or is pending when the home health agency requests a claim number, the district office will give the agency the claim number when processing is completed. The agency may then send the start of care notice information to the intermediary (or to the district office if the agency deals directly with SSA).



## 320. START OF CARE NOTICE

When a patient 65 years or older begins home health services, the home health agency will complete the start of care notice part (items 1-16) of Form SSA-1487, Home Health Agency Report And Billing Form (see Exhibit 4, § 399). When signed, this represents the patient's request for payment of benefits. See §§ 235 ff.

When these items are completed, furnish the start of care information to the intermediary (or to the appropriate Social Security Administration district office if the agency deals with SSA). This information may be forwarded by mail, messenger, or telephone depending on prior arrangements made with the intermediary or the SSA district office. The bottom two copies of Form SSA-1487 can be sent to the intermediary as the start of care notice if the arrangement so provides. If some other means of transmitting start of care information to the intermediary is used, these copies of the form may be discarded.

See § 325 for proper entries for items 1-16 of Form SSA-1487.

## 322. WHEN THE AGENCY SUBMITS A START OF CARE NOTICE

A start of care notice is required in the following situations:

a. The patient will receive home health services under Part A after a qualifying stay in a hospital or extended care facility.

b. The patient will receive initial home health services under Part B. This applies when services will be under Part B from the beginning.

c. The patient is discharged from a home health plan of treatment, and the physician later establishes a new plan for services, whether or not it differs from the prior plan.

d. The patient receives home health services from one agency and transfers to another agency.

e. The patient initially received Part B services, and later has a qualifying inpatient stay which entitles him to Part A visits.

f. A patient receiving Part A home health visits has a qualifying stay in a hospital or extended care facility which begins a new spell of illness and entitles him to a new series of 100 Part A visits.

g. The patient's home health visits are suspended for more than 60 days and are resumed after the 60th day. (Note: For the purpose of medicare reimbursement, the patient's home health plan is considered terminated if visits are not furnished for more than 60 days, see § 425.)

## 323. WHEN THE AGENCY NEED NOT SUBMIT A START OF CARE NOTICE

A start of care notice is not required in the following situations:

a. The same home health agency transfers services from Part A to Part B because either visits have been exhausted under Part A or a new spell of illness has begun.

b. Services furnished under Part B extend from one calendar year into another.

c. The same home health agency resumes Part A or Part B home health visits after a temporary suspension for a period no longer than 60 days. (See § 425.)

d. The patient is receiving Part A home health visits, and is readmitted to a hospital or extended care facility in the same spell of illness, and visits continue after discharge from the institution.

## 325. HOW THE AGENCY COMPLETES A START OF CARE NOTICE (FORM SSA-1487)

All entries should be typed or printed clearly. Show month, date, and year in six digit numbers, e.g., 10/01/67.

**Item 1. Patient's Name.**—Enter the patient's name as it is shown on his health insurance card. Do not make any changes in the name (except to show the last name first). The SSA master computer record is kept under this name.

**Item 2. Health Insurance Claim Number.**—Enter the patient's health insurance claim number as shown on his health insurance card, Certificate of Award, Notice of Hospital or Medical Insurance Utilization, Temporary Notice of Eligibility, or as reported by the social security district office.

**Item 3. Patient's Address.**—Enter the patient's mailing address. If the address is an institution, enter the name of the institution. Note: An individual in an institution meeting the basic definition of a hospital or extended care facility cannot be considered to be in a place of residence for purposes of receiving covered home health services; see § 208.5.

**Item 4. Date of Birth.**—Enter the patient's date of birth. If the year of birth is unknown, make no entry. If the year is known but the month or day is unknown enter "00" for the missing item, e.g., 00/00/95.

While the date of birth is useful as identification and



should be shown when available, a start of care notice will be processed without the date of birth.

**Item 5. Sex.**—Enter “X” in the appropriate box.

**Items 6 and 7. Home Health Agency Identification.**—Enter the name and address of the agency and the agency’s health insurance provider number. This information may be preprinted on all copies of the agency’s supply of these forms.

**Item 8. Medical Record Number.**—Enter the patient’s medical record number if one is assigned by the agency, and it is needed for the purpose of associating files or for referral purposes.

**Item 9. Name and Address of Attending Physician.**—Enter the name of the attending physician. The name should be that of the physician who established the plan and will certify and recertify the medical necessity of the home health visits. Show the address only if your intermediary requires this information.

If the plan was set up by an outpatient clinic rather than by a private physician, enter that information. However, if it is known that only one physician or department of the clinic is involved, enter that information.

**Item 10. Date Care Started.**—Enter the date on which covered home health services actually began. (This cannot be earlier than the patient’s effective date of health insurance (Part A or Part B) entitlement.) This date will remain the same on subsequent bills even if (a) the patient transfers from one agency to another or (b) Part B visits will be made because either Part A visits are exhausted or a new spell of illness has begun.

If reimbursable services not charged as visits, e.g., medical supplies and appliances, are furnished before the first visit, Item 10 will be the date these services were first furnished.

**Item 11. Name and Address of Institution, Etc.**—If home health visits follow a qualifying inpatient stay,

enter the name and address of the hospital or extended care facility.

To qualify for visits under Part A—

a. A spell of illness must have begun (see §§ 112.3 and 210.1).

b. Visits must follow an inpatient hospital stay of at least 3 consecutive days or a covered stay of any duration in an extended care facility (see § 210.2).

c. No more than 14 days can pass between discharge from a qualifying stay in a hospital or extended care facility and the establishment of a plan (see § 210.3). However, a plan may be established before the patient is discharged.

In the unusual situation where inpatient stays in two different institutions qualify the patient for Part A visits, i.e., one starts a spell of illness and the other satisfies the prior stay requirement (see § 210.2), the names and addresses of both institutions should be shown in Item 11. If verified, the dates of the stay which began the spell of illness should also be shown in Item 11. See example below.

**Item 12. Verified Dates of Stay in Item 11.**—Enter the verified dates of the inpatient stay qualifying visits under Part A only when the dates are taken from the official referral sheet of the hospital or extended care facility. Verified dates entered on the initial bill, need not be repeated on subsequent bills.

Home health agencies may wish to make arrangements with other providers to include the verified dates of stay as part of the normal information furnished when home health visits will follow a qualifying stay.

If inpatient stays in two different institutions qualify the patient for Part A visits (see Item 11 above), the dates of stay that began the spell of illness should be entered in Item 11 and the dates of the qualifying prior stay should be entered in Item 12. See example below.

**Example: Two inpatient stays meet spell of illness and prior stay requirements.**

10. DATE CARE STARTED	11. NAME AND ADDRESS OF INSTITUTION, IF ANY, CARING FOR CONDITION LATER REQUIRING HOME HEALTH SERVICES	12. VERIFIED DATES OF STAY IN ITEM 11	13. DATE HOME HEALTH PLAN ESTABLISHED
0 8   2 5   6 7	St. George Hospital, 16 Court St., Balto, Md. 08/18/67-08/19/67 Convalesarium Nursing Home, 8 Reade St., Balto. Md.	FROM   TO 08   20   67   08   24   67	08   24   6 7

**Item 13. Date Home Health Plan Established.**—Show the date on which the patient's attending physician established the plan for home health services.

The date shown in Item 13 can be **no later** than the "Date Care Started" shown in Item 10.

Home health services may be authorized verbally by a physician. In this case, the date of verbal authorization will be shown. However, the agency must make sure the plan is reduced to writing within 14 days of discharge from the qualifying stay in a hospital or extended care facility, if payments are to be made under Part A. If the services are payable only under Part B, the plan must be reduced to writing before a bill is submitted to the intermediary.

**Item 14. Payment Source, etc.**—Check the appropriate box to indicate how charges not reimbursed by health insurance will be paid.

If Item E (Public Agency) is checked, enter the name and address of the public agency and, if it is available, the case number assigned to the patient by the public agency. This information will be useful to the intermediary if it needs to forward a copy of the billing form to the public agency.

Item 14 may be completed on the first billing instead of on the start of care notice if the agency prefers. If the agency will not bill anyone for expenses not reimbursable under medicare, the item should not be completed.

**Items 15 and 16. Patient's Certification and Payment Request, and Diagnosis.**—These two items should be completed but if diagnosis is not readily available do not delay sending the start of care notice. For details on completion of these two items see § 405.

### 330. CONTENTS OF INTERMEDIARY REPLY TO START OF CARE NOTICE

The reply to the start of care notice will be furnished by the intermediary to the agency according to prior arrangements. (If the agency deals directly with the Social Security Administration, it will receive a form reply to the start of care notice from the Bureau of Health Insurance, Direct Reimbursement.) The contents of the reply will be based on the intermediary's query of the SSA central record for eligibility information, and any necessary investigation of prior inpatient hospital or extended care facility stays or home health services.

The "Report of Eligibility" part of the home health agency report and billing form (see Exhibit 4) may be

used as a reply to the start of care notice, where it is received by the intermediary as part of the start of care notice from the agency. Whether the reply will be given by telephone, mail, or wire to the agency, it will contain eligibility information similar to the content of the "Report of Eligibility." An explanation of the eligibility information in the "Report of Eligibility" is outlined below:

**A. Effective Date—Hospital Insurance.**—The month, day, and year of the patient's entitlement to hospital insurance benefits (Part A) will be shown. If not entitled, the entry will so indicate.

**B. Effective Date—Medical Insurance.**—This will show the month, day, and year of the patient's entitlement to medical insurance (Part B). The entry will so indicate if the patient is not entitled to Part B benefits.

**C. Date of Start of Care.**—This date will be the one furnished by the agency in the start of care notice.

**D. Hospital Insurance Visits Available.**—This will show the remaining number of visits which may be reimbursed under Part A, based on the SSA central record and the information available to the intermediary.

**E. Supplementary Medical Insurance Visits Available.**—This will show the potential remaining home health visits which may be reimbursed under Part B.

**F. Last Discharge Date.**—The last discharge from an inpatient hospital or covered extended care facility stay will be shown.

**G. Medical Plan Deductible.**—This will show if the \$50 deductible is "met" or "not met," but if not met will not indicate how much remains to be met. If the reply shows "not met," the home health agency should ask the patient whether he has had other expenses that have been or could be applied toward the deductible (see § 220.1). If the reply shows "not met" the intermediary must requery the SSA central record when it receives a Part B bill for payment from the home health agency in order to learn the amount of the deductible remaining to be met.

**H. Outpatient Psychiatric Expense.**—Whether the \$500 limitation has been "met" or "not met" will be shown in this item. If not met, the amount remaining to be met will not be shown. This item is informational only. The limitation applies only to expenses incurred for physicians' services.

**I. Remarks.**—Any necessary explanation of eligibility information will be shown. This will include



corrections in the name or health insurance claim number reported by the agency. When changes of this sort are reported, the name and claim number information on the billing form should be changed to reflect the correct name or health insurance claim number.

If the name and claim number information were not matched, the intermediary will request the home health agency to check its record, or to contact the patient or the nearest district office to obtain a valid claim number.

The agency may also be requested to verify reports of death shown in the patient's SSA central record.

**J. Open Item.**—The information in this block will be completed by the intermediary when verifying reports of open items (open items are admissions or carestarts which are recorded in SSA central records, but are not yet closed out by the processing of a bill).

Where there is an open item reported from SSA central records to the intermediary or the Bureau of Health Insurance, Direct Reimbursement, either the intermediary or Direct Reimbursement will contact the "open item" provider to verify the stay, the date of the prior discharge, and the status of the bill. The intermediary or the Bureau of Health Insurance, Direct Reimbursement, will use this information to determine whether Part A benefits are payable and to compute the number of visits remaining under Part A and Part B.

### **340. RETROACTIVE ENTITLEMENT**

When an application for social security benefits is filed by a person over 65 years of age, he may inform the social security office that he received home health services in the retroactive period of up to 12 months for which he may be entitled to benefits. Payment for the home health services (Part A only) received in this period is possible (see §120). The social security office will tell the individual to get in touch with the agency. In these cases, follow the start of care procedure to obtain a report of eligibility from your intermediary before billing. If the patient had paid the agency, the agency should refund the appropriate amount.

### **399. EXHIBITS**

**Exhibit 1.** Health Insurance Cards and Claim Numbers.

**Exhibit 2.** Your Record of Hospital Insurance Benefits Used Under Medicare (Form SSA-1533).

**Exhibit 3.** Notice of Medical Insurance Utilization (Form SSA-1533A).

**Exhibit 4.** Home Health Agency Report and Billing (Admission Copy) (Form SSA-1487).

**Exhibit 5.** Certificate of Social Insurance Award.

**Exhibit 6.** Temporary Notice of Eligibility.



## HEALTH INSURANCE CARDS

Health Insurance	
SOCIAL SECURITY ACT	
NAME OF BENEFICIARY <b>JANE Q. DOE</b>	
CLAIM NUMBER <b>000-00-0000B</b>	SEX <b>FEMALE</b>
IS ENTITLED TO	EFFECTIVE DATE
HOSPITAL INSURANCE	<b>7-1-66</b>
MEDICAL INSURANCE	<b>7-1-66</b>
SIGN HERE	

Front

Health Insurance	
RAILROAD RETIREMENT BOARD	
NAME OF BENEFICIARY <b>JOHN C. DOE</b>	
CLAIM NUMBER <b>A-000-00-0000</b>	SEX <b>MALE</b>
IS ENTITLED TO	EFFECTIVE DATE
HOSPITAL INSURANCE	<b>7-1-66</b>
MEDICAL INSURANCE	<b>7-1-66</b>
SIGN HERE	

Front

1. Carry your card with you when you are away from home.
2. Let your hospital or doctor see your card when you require hospital, medical or health services under "Medicare."
3. Get in touch with your social security office if you have questions about your rights under "Medicare."
4. Your card is good wherever you live in the United States.

WARNING: Issued for the sole use of the holder designated hereon. Intentional misuse of this card is unlawful and will make the offender liable to penalty.

PROPERTY OF UNITED STATES GOVERNMENT.  
IF FOUND DROP IN NEAREST U.S. MAIL BOX.

Return To: SOCIAL SECURITY ADMINISTRATION  
Baltimore, Maryland 21235

FORM SSA-1966 (7-66)

Back

1. Carry your card with you when you are away from home.
2. Let your hospital or doctor see your card when you require hospital, medical or health services under "Medicare."
3. Get in touch with your Railroad Retirement Board office if you have questions about your rights under "Medicare."
4. Your card is good wherever you live in the United States. For benefits in Canada, write to the Railroad Retirement Board.

WARNING: Issued for the sole use of the holder designated hereon. Intentional misuse of this card is unlawful and will make the offender liable to penalty.

PROPERTY OF UNITED STATES GOVERNMENT.  
IF FOUND DROP IN NEAREST U.S. MAIL BOX.

Return to: RAILROAD RETIREMENT BOARD  
844 Rush Street, Chicago, Illinois 60611

Form G-43 (2-66)

Back

## HEALTH INSURANCE CLAIM NUMBERS

Most HI claim numbers are 9 digits with a letter or letter and numeral suffix; e.g., 000-00-0000B or B1. They may also be 6-or-9-digit numbers with lettered prefixes; e.g., A000000, A-000-00-0000; or WD-000000, WD-000-00-0000. Numbers with one or more letter prefixes identify Railroad Retirement Board annuitants.

Possible suffixes are:

A, B, B1, B2, B3, B4, B5, B6, or B9

C1, C2, C3, C4, C5, C6, C7, C8, or C9

D, D1, D2, D3, D4, D5, D6, or D7

E, E1, E2, or E3

F1, F2, F3, F4, F5, F6, F7, or F8

HB, HB1, HB2, HB3, HB4, HB5, HB6, or HB9

HC1, HC2, HC3, HC4, HC5, HC6, HC7, HC8, or HC9

J1, J2, J3, J4 (For subscripts "3" and "4" there can be no entitlement to hospital insurance benefits.

K1, K2, K3, K4 Supplementary medical insurance entitlement may exist for all J and K suffixes.)

M, M1, and T (Suffix letter "T" indicates entitlement to hospital or hospital and medical insurance; letters M and M1 indicate that the patient is eligible for supplementary medical insurance benefits but not for hospital insurance benefits.)

When the status of a beneficiary changes, it is possible for the suffix of his claim number to change.

EXHIBIT 2

Your Record of Hospital Insurance Benefits Used Under Medicare, SSA-1533



DEPARTMENT OF  
HEALTH, EDUCATION, AND WELFARE  
SOCIAL SECURITY ADMINISTRATION

**YOUR RECORD OF HOSPITAL INSURANCE  
BENEFITS USED UNDER MEDICARE**

(THIS IS NOT A BILL)

┌

┐

DATE:

YOUR CLAIM NUMBER:

└

┘

In any correspondence, please refer to this number. ▲

Dear Beneficiary:

Recently, your Medicare Hospital Insurance helped pay for the services described below. We are pleased that your social security program was able to assist you.

**1. OUR RECORDS SHOW THAT YOU RECEIVED THESE SERVICES**

SERVICES WERE PROVIDED BY

TYPE OF SERVICES

WHEN

TO

Your Medicare Hospital Insurance has paid the cost of all COVERED SERVICES except:

For information about any services NOT COVERED by your Medicare Hospital Insurance, please see other side.

If you have any questions about this record, please get in touch with: ►

**2. OUR RECORDS NOW SHOW THESE BENEFIT TOTALS**

USED THIS TIME

TOTAL USED

AVAILABLE TO USE FOR  
THIS "SPELL OF ILLNESS"  
(See "D" on other side.)

INPATIENT HOSPITAL DAYS \_\_\_\_\_

EXTENDED CARE FACILITY DAYS \_\_\_\_\_

HOME HEALTH VISITS \_\_\_\_\_

► If you again use services which are covered by your Medicare Hospital Insurance, please show this Record and your Health Insurance Card to the organization providing services.  
SEE OTHER SIDE FOR ADDITIONAL INFORMATION.

Sincerely yours,

*Robert M. Ball*

Robert M. Ball  
Commissioner of Social Security

## EXHIBIT 3

Notice of Medical Insurance Utilization, SSA-1533A

FORM SSA-1533A (5-66)



DEPARTMENT OF  
HEALTH, EDUCATION, AND WELFARE  
SOCIAL SECURITY ADMINISTRATION  
BALTIMORE, MARYLAND 21235

## NOTICE OF MEDICAL INSURANCE UTILIZATION

NAME AND ADDRESS OF THE BENEFICIARY  
OR REPRESENTATIVE OF THE BENEFICIARY

DATE:

HEALTH INSURANCE CLAIM NUMBER:

The bill for MEDICAL INSURANCE services described below was recently submitted under your health insurance claim number and recorded to your account.

TYPE OF SERVICES	DATES COVERED BY BILL		NUMBER OF HOME HEALTH VISITS INCLUDED
	FROM	TO	

Institution or agency  
furnishing services

Office which handled  
your claim

Each year, as soon as your covered medical expenses go over \$50, your MEDICAL INSURANCE will pay 80 percent of the reasonable costs or charges for all additional covered services for the rest of the year. The computation of MEDICAL INSURANCE benefits for this bill is shown below.

TOTAL COVERED CHARGES	AMOUNT TOWARD \$50 DEDUCTIBLE	20% PAYABLE BY BENEFICIARY	TOTAL PAYABLE BY BENEFICIARY

## STATUS OF MEDICAL INSURANCE RECORD

As of the date of this notice, the status of your MEDICAL INSURANCE record is as follows:

*Robert M. Ball*

Robert M. Ball  
Commissioner of Social Security

PLEASE READ THE OTHER SIDE OF THIS NOTICE FOR IMPORTANT INFORMATION.



## EXHIBIT 4

## Home Health Agency Report And Billing, SSA-1487 (Admission Copy)

<small>DEPARTMENT OF HEALTH, EDUCATION, AND WELFARE SOCIAL SECURITY ADMINISTRATION</small> <b>HOME HEALTH AGENCY REPORT AND BILLING</b>		Form Approved. Budget Bureau No. 72-R736	
1. PATIENT'S LAST NAME		FIRST NAME	MI
2. HEALTH INSURANCE CLAIM NUMBER			
3. PATIENT'S ADDRESS (Street number, City, State, Zip Code)		4. DATE OF BIRTH	5. SEX <input type="checkbox"/> M <input type="checkbox"/> F
6. HOME HEALTH AGENCY NAME AND ADDRESS		7. PROVIDER NO.	9. NAME AND ADDRESS OF ATTENDING PHYSICIAN
		8. MEDICAL RECORD NO.	
10. DATE CARE STARTED	11. NAME AND ADDRESS OF INSTITUTION, IF ANY, CARING FOR CONDITION LATER REQUIRING HOME HEALTH SERVICES		12. VERIFIED DATES OF STAY IN ITEM 11 FROM TO
			13. DATE HOME HEALTH PLAN ESTABLISHED
14. PAYMENT SOURCE FOR CHARGES TO PATIENT A. <input type="checkbox"/> SELF OR FAMILY    C. <input type="checkbox"/> BLUE CROSS BLUE SHIELD    E. <input type="checkbox"/> PUBLIC AGENCY (Give name) B. <input type="checkbox"/> PRIVATE INSURANCE    D. <input type="checkbox"/> EMPLOYER OR UNION    F. <input type="checkbox"/> OTHER (Explain)			
15. PATIENT'S CERTIFICATION: AUTHORIZATION TO RELEASE INFORMATION AND PAYMENT REQUEST: I certify that the information given by me in applying for payment under Title XVIII of the Social Security Act is correct. I authorize release of all records required to act on this request. I request that payment of authorized benefits be made in my behalf.			
SIGNATURE (Patient or authorized representative) (Signature by mark must be witnessed)			DATE
16. DIAGNOSES			LEAVE BLANK
EMPLOYMENT RELATED    A. <input type="checkbox"/> YES    B. <input type="checkbox"/> NO (If yes, give name and address of employer.)			
<b>REPORT OF ELIGIBILITY</b>			
A. EFFECTIVE DATE, HOSPITAL INSURANCE		J. OPEN ITEM	
B. EFFECTIVE DATE, MEDICAL INSURANCE		1. INTERMEDIARY	
C. DATE OF START OF CARE			
D. HOSPITAL INSURANCE VISITS AVAILABLE			
E. MEDICAL INSURANCE VISITS AVAILABLE			
F. LAST DISCHARGE DATE		2. PROVIDER	
G. MEDICAL PLAN DEDUCTIBLE <input type="checkbox"/> MET <input type="checkbox"/> NOT MET			
H. OUTPATIENT PSYCHIATRIC EXPENSE <input type="checkbox"/> MET <input type="checkbox"/> NOT MET		3. ADMITTED	
I. REMARKS:		4. DISCHARGED	
APPROVED BY		DATE	
FORM SSA-1487 (4-66)			
<b>ADMISSION COPY</b>			

## EXHIBIT 5

DISTRICT OFFICE

DEPARTMENT OF  
HEALTH, EDUCATION, AND WELFARE  
SOCIAL SECURITY ADMINISTRATION

CLAIM NUMBER

**Certificate of Social Insurance Award**

PAYMENT CENTER:

DATE:

THIS IS TO CERTIFY THAT THE PERSON(S) NAMED BELOW BECAME ENTITLED TO THE INSURANCE BENEFITS SHOWN,  
PAYABLE UNDER TITLE II OF THE SOCIAL SECURITY ACT.NAME AND ADDRESS OF PAYEE AS THE CLAIMANT  
OR AS REPRESENTATIVE OF THE CLAIMANTDATE OF  
ENTITLEMENTMONTHLY  
BENEFITAMOUNT OF  
FIRST CHECK

TYPE OF BENEFIT:

The right to receive social security benefits carries with it certain responsibilities. They are explained in the enclosed booklet. Read this booklet carefully. Be sure that you understand clearly what you can expect by way of benefits, and what is to be expected of you.

**NOTICE:** If you believe that this determination is not correct, you may request that your case be reexamined. If you want this reconsideration, you must request it not later than 6 months from the date of this notice. You may make any such request through your social security office. If additional evidence is available, you should submit it with your request.

ROBERT M. BALL  
COMMISSIONER OF SOCIAL SECURITY

FORM OA - 30 (8 - 65)

**KEEP AS A PERMANENT RECORD—DO NOT DESTROY**

EXHIBIT 6

TEMPORARY NOTICE OF ELIGIBILITY

District Office Address:

Date:

Dear \_\_\_\_\_:

Based on the information you have given to the Social Security Administration you will be eligible for hospital insurance benefits beginning (mo.) (yr.) and for supplementary medical insurance benefits beginning (mo.) (yr.). Your eligibility will continue for 60 days from the date shown at the top of this notice unless you are notified otherwise during the 60-day period.

To obtain medical services before you receive your card, show this letter to your hospital or doctor but keep the letter with you. This temporary notice of eligibility is to be used only by the person to whom it is addressed. Misuse is unlawful and will make the offender liable to a penalty.

This letter should be destroyed as soon as you receive your health insurance card or other notice concerning your eligibility.

Sincerely yours,

Robert M. Ball  
Commissioner of Social Security

IMPORTANT

When services are provided on the basis of this notice, all bills or correspondence with an intermediary or the Social Security Administration should show the patient's social security claim number.



## Chapter IV

### HOME HEALTH AGENCY BILLING PROCEDURES

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## Chapter IV

### HOME HEALTH AGENCY BILLING PROCEDURES

#### 400. INTERVIEWING THE PATIENT ABOUT HIS DEDUCTIBLE STATUS

If it is apparent that the home health services will be charged to supplementary medical insurance rather than to hospital insurance, i.e., there was no prior hospital or extended care facility stay, the plan was not established within 14 days of discharge, benefits were exhausted under a Part A plan, or the home health agency specializes in treating mental diseases, the home health agency will want to discuss the patient's deductible status with him or his representative. (For more detailed information about the deductible, see § 220.1.)

Before the home health agency attempts to collect the \$50 deductible or any portion of it, it should satisfy itself that the deductible has not been met. This should be done by a careful interview with the patient, or a member of his family or other person if he is unable to conduct his own affairs, and by reference to the intermediary's reply to the start of care notice.

The intermediary's reply to the start of care notice will indicate whether the deductible has been met or not met. However, if the reply indicates that the deductible has not been met, there will be no indication of the remaining expenses needed to satisfy the deductible. The patient, in that event, may have a medicare utilization notice or explanation of benefits indicating what part of the deductible he has met. If he has such a notice, the home health agency may collect from the patient the portion of the deductible not met. If the patient has bills for other expenses which could meet the deductible he should submit them promptly to the medical insurance carrier and it will not be necessary for the agency to collect any part of the deductible.

When the intermediary receives the agency's billing, it will query the Social Security Administration central record for the amount of the deductible remaining to be met.

Any overpayments by the patient for the deductible, discovered when the intermediary verifies the status of the deductible with the Social Security Administration, will be refunded to the patient by the intermediary and the agency payment adjusted accordingly.

If the agency collects less than is due, the intermediary will notify it of the amount remaining to be

collected on the deductible after processing the bill.

The agency should not bill a third party until the patient's deductible status is known.

#### 401. GENERAL BILLING INFORMATION

Form SSA-1487, Home Health Agency Report and Billing, is the billing form for covered services furnished a medicare patient.

You should submit billings on a regular basis until the allowable visits are exhausted. However, you should always submit a billing when services are terminated, visits are exhausted, or charging of visits is to be changed from posthospital to medical, or vice versa.

*Services provided in different accounting years should not be put on the same bill.* At the end of your accounting year, you should submit a bill which contains all services furnished to the patient since the last bill and through the end of the year. Services furnished in the following accounting year should be on a separate bill.

A fully completed billing form should also be submitted when:

a. Part B visits and other services have been rendered and the deductible has not been met.

b. The patient or his representative refuses to request that payment be made on his behalf. Show "Refused Payment" in the open area under Item 22. (Your intermediary can furnish instructions on how to bill if the patient subsequently decides to request payment.)

#### 405. COMPLETION OF HOME HEALTH AGENCY BILLING (FORM SSA-1487)

Examples of completed billing forms are in § 450. *Items 1 through 14* should be completed on the initial billing in the manner described in § 325 (start of care notice).

*Items 4, 5, 9, 14, 15, and 16* may be omitted on second and subsequent billings. *Items 11 and 12* may also be omitted on subsequent billings unless there are later inpatient stays in a hospital or extended care facility (see below).

*Items 11 and 12. Name and Address of Institution, etc., and Verified Dates, etc.*—The information given



on the initial billing on prior inpatient stays should not be repeated on the second or subsequent billings. However, any subsequent inpatient stays in a hospital or extended care facility should be reported in these items on the next billing. The dates of stay should be entered only if verified with the institution. Once a later inpatient stay has been entered on a billing it should not be repeated on a subsequent billing.

This later information on inpatient admission and discharge is needed to determine if a new spell of illness has begun or the 1-year period for visits has been extended. See § 215.1 for the effect of a later stay on entitlement to Part A home health visits.

Entries in these items do not affect other items on the SSA-1487 unless they start a new spell of illness. The original "Date Care Started" (Item 10) and "Date Home Health Plan Established" (Item 13) will remain the same.

**Item 13. Date Home Health Plan Established.—**

Never make more than one entry on a billing form in this item. If Part A visits are involved, the entry is the date the initial plan was established in the spell of illness for which you are billing. The fact the initial plan is amended, the patient is reinstitutionalized in the same spell of illness, Part A visits have been exhausted and Part B visits will begin, care extends from one year into another, etc., is immaterial. This same date could, therefore, be shown on subsequent bills for a number of years. However, a new date plan established is shown if the patient becomes eligible for a new series of Part A visits, regardless of whether he was previously receiving visits under Part A or Part B.

**Item 15. Patient's Certification and Payment Request.—**Have the patient or his authorized representative read the statement on the form or on the agency's record if it uses the alternate signature procedure (see below). If the signature is obtained on Form SSA-1487, it is sufficient if it is legible only on the original.

If the patient cannot sign his name because of his physical or mental condition, another person may sign on his behalf, e.g., John J. Jones by Jack A. Smith. (Obtain a brief statement that shows both why the patient himself did not sign the form and the relationship of the signer to the patient. Retain the explanation in the agency's file if the signature is obtained on the agency's own record. If the signature is on Form SSA-1487, the explanation should accompany or be included in the billing form. In certain situations, a home health agency representative may sign on behalf of the patient. (See § 235.1 for who may sign a request for payment.))

The statement should be read to a patient who signs by mark. A signature by mark should be witnessed by a person who knows the patient.

**Signature on Agency Record.—**The agency may arrange with its intermediary to have the patient's signature on its records serve as the request for payment.

The agency should then incorporate the language now on the SSA-1487 by printing or stamping it on either the agency's own start of care form or on a separate form attached to or associated with that form. The following format is suggested:

**"Statement To Permit Payment for Home Health Services or Hospital Insurance and Medical Insurance Benefits to Home Health Agency**

"I certify that the information given by me in applying for payment under Title XVIII of the Social Security Act is correct. I authorize release of all records required to act on this request. I request that payment of authorized benefits be made on my behalf."

The original copy of the first billing form submitted by the agency for services to a patient should be stamped or typed on the patient's signature line to indicate that the patient's statement is on file. The following wording is suggested: "Patient's request for payment on file."

When the intermediary and agency have arranged to put this procedure into effect, the intermediary will thereafter make payment without the patient's signature on the billing form, as long as home health services are being received from the same agency under the same plan of treatment.

**Item 16. Diagnoses.—**Complete on the initial bill. Home health visits under Part A must be related to a condition for which the patient was receiving inpatient hospital or extended care treatment (see § 240.1). Enter all diagnoses as furnished by the attending physician. List the primary diagnosis first with "Primary" in parentheses.

Show the diagnosis in accordance with recognized nomenclature, e.g., "Current Medical Terminology," or "Standard Nomenclature of Diseases and Operations."

This item need not be completed on subsequent bills, but if other diagnoses are identified between the initial and final bills, note such changes or additional diagnoses on the final bill.

Enter an "X" in the appropriate check box to indicate whether or not the condition is employment re-

lated. If the condition is known to be employment related, enter the name and address of the employer on the initial bill. (See §§ 250-250.2 if workmen's compensation is involved.)

**Item 17. Statement Covers Period.**—Show the beginning and ending dates of the period covered by this bill.

On the first bill for services under a plan of treatment, the "From" date cannot be earlier than the date care started in Item 10.

On the final bill, the "To" date can be no later than the date in Item 20; that is, the date of death, the date discharged, or the date visits are exhausted.

If a patient is discharged or dies after your most recent bill indicated that he was still receiving services, and before receiving additional services, prepare a no-payment bill in accordance with the instructions in § 430.

**Item 18. Date First and Last Visit.**—Do not complete this item. It will be eliminated when the home health billing form is revised.

**Item 19. Patient Status.**—Check only one block to show whether, at the end of the period covered by the bill, the patient is still receiving services, has been discharged, has died, or visits have been exhausted.

In addition to cases in which the patient is discharged because home health services are no longer required, the "Discharged" block will be checked in the following situations:

a. The patient has exhausted his visits and does not need additional home health visits or Part B services.

b. The patient is covered under either Part A or Part B and has exhausted visits under that part although visits will continue.

c. The patient is discharged on the same day visits are exhausted.

d. The patient transfers from Part B to Part A.

e. A stay in the hospital or extended care facility starts a new spell of illness but does not meet the prior stay requirement and the patient is not entitled to Part B.

f. The patient transfers from one agency to another under the same plan of treatment.

g. The final bill for equipment rental.

h. The time limit on Part A visits expires even though the visits are not exhausted. (However, if visits continue under Part B, see § 410.)

The "Visits Exhausted" block will be checked when the patient is covered under both Part A and Part B, has exhausted his visits under both parts and needs

additional home health visits or Part B services (for exception in billing for rental of durable medical equipment, see § 420).

**Item 20. Date Applicable to Item 19.**—A date must be entered in Item 20 if the patient was discharged, died, or his visits were exhausted in the period covered by this bill. It should never be earlier than the "To" date in Item 17.

If the "Still Receives Services" block in Item 19 is checked, make no entry in Item 20.

**Item 21. Statement of Services Rendered.**—From the information received on the start of care notice and other information, the intermediary will advise you whether charges are to be billed under Part A or Part B. If the first billing is under Part A, continue billing under Part A until the patient is discharged, dies, visits are exhausted, a new spell of illness starts, or the year in which visits must be made has ended.

All covered services and items which have been furnished in the billing period must be included in the bill which is being submitted.

Visits to perform noncovered services should not be shown as visits on the billing form. Some examples of such services are homemaker services and "meals on wheels." See §§ 230 and 232 for additional examples. However, see § 430 for rules on submitting no-payment bills.

Home health services furnished on an outpatient basis at a hospital, extended care facility, or rehabilitation center and billed through the home health agency, should be shown on the billing form as if the home health agency had directly furnished the services. (See §§ 200.2 and 205.7.)

**Note:** Diagnostic services furnished to home health patients in the outpatient department of a participating hospital are not covered home health services and should be billed by the hospital.

**Item 21 A-G.** Show the **total** number of visits and **total** charges for each category of services in A through F.

If any home health services are furnished on an outpatient basis (see § 205.7), the initials OP and the number of outpatient visits should be entered in the space immediately following the name of the particular service, e.g., "B. Physical Therapy OP (3)."

If visits are made by individuals in categories other than those listed in A through F, enter the category, (eg., intern) in G with the pertinent number of visits and charges. It is not necessary to show how the charges were determined. For example, if there were 5 one-hour



visits by a home health aide at a charge of \$2 per hour, Item 21F would indicate 5 visits, charges \$10.

The number of visits by and charges for services of an unaccompanied student nurse should be entered in 21A. If a registered nurse who is employed by the home health agency accompanies the student to observe her or the purpose of the student visit is to observe the registered nurse, only one visit should be charged. In either situation such visits and charges would be entered in 21A.

See §§ 218.1 and 218.2 for how to count visits.

**Item 21 H and I.** When an agency bills on the basis of the same charges per unit of service (e.g., visit, week, month) the total number of units will be entered in the unshaded area in H and the charge per unit will be entered in the unshaded area of I (see example below). The number of visits must also be shown in the appropriate category, A through G. No charges need be shown in A through G. No entries should be made in the shaded areas of H and I.

21 STATEMENT OF SERVICES RENDERED		POST-HOSPITAL PLAN		MEDICAL PLAN	
PRIMARY PURPOSE OF VISIT	NO VISITS	CHARGES	NO VISITS	CHARGES	
A. Skilled Nursing Care		\$		\$	
B. Physical Therapy	3				
C. Speech Therapy					
D. Occupational Therapy	2				
E. Medical Social Services	1				
F. Home Health Aide					
G. Other Visits (Specify)					
H. Total No. of Units of Service	6				
I. Charge per unit of Service \$	5.00				
J. TOTALS	6	\$ 30 00		\$	
K. Other (Specify)					
L. TOTAL CHARGES		\$ 30 00		\$	

**Item 21J. Totals.**—Show the total number of visits and total charges listed in A through G. If the agency charges on the basis of a unit of service only, the total charges should be H times I.

**Item 21K. Other.**—Enter in this space charges for covered home health services which are not counted as visits. Enter each medical appliance and category of supply on a separate line with the charge for the item shown on the same line.

See § 420 for payment for rental of equipment when no plan is in effect.

**Item 21L. Total Charges.**—Enter the sum of charges in 21J and 21K. Do not show total visits.

**Item 21M. Amount Paid by Patient.**—This item re-

lates only to amounts paid toward the Part B deductible and coinsurance. On initial bills, only the amounts **actually paid** by or on behalf of the patient in the period covered by the bill should be entered. The actual amount paid by the patient will permit the intermediary to determine if he is entitled to a refund. If the agency collected less than is due, the intermediary will advise it of the exact amount that should be billed for the deductible and coinsurance.

This item should be blank on second and subsequent bills. In subsequent billing periods, the agency is responsible for making the refund to the patient if deductible and coinsurance amounts are overcollected.

**Item 22. Computing Reimbursement Under Part A (Post-Hospital Plan).**—This item is designed to determine the interim amount payable under Part A. The computation may be made either by the agency or the intermediary.

**Item 22A. Total Charges.**—Enter the total Part A (post-hospital plan) charges from Item 21L.

**Item 22B. Reimbursement Rate.**—Show the reimbursement rate agreed upon by the agency and the intermediary. It is the **percentage** relationship of the agency's costs to its charges.

**Item 22C. Reimbursement Amount A Times B.**—Multiply the total charges (22A) by the reimbursement percentage rate (22B) to determine the interim reimbursement amount.

**Item 23. Computing Reimbursement Under Part B (Medical Plan).**—The agency should **not** complete this item unless it knows that the \$50 deductible has been met.

**Item 23A. Verified Deductible.**—If the deductible has been met, enter "0" (zero). If you do not know that the deductible has been met, make no entry.

**Item 23B. Verified Coinsurance.**—If the deductible has been met, enter 20 percent of the total medical plan charges in Item 21L.

**Item 23C. Total Charges.**—Enter the amount shown in the medical plan column in Item 21L.

**Item 23D. Reimbursement Rate.**—This must **always** be a percentage. It will be the percentage relationship of the agency's costs to its charges.

**Item 23E. C Times D.**—Enter the total charges (Item 23C) multiplied by the reimbursement rate (Item 23D).

**Item 23F. E Less A.**—If the deductible has been met, enter the Item 23E amount. If the deductible has not been met, make no entry.



**Item 23G. Reimbursement Amount 80 Percent of F.**—Multiply Item 23F by 80 percent. (It is important to note that even though the deductible to be met exceeds total charges a payment to the agency is possible if the reimbursement rate (Item 23D) is over 100 percent. **Example:** Deductible to be met is \$20, total charges \$15, reimbursement rate 150 percent. Charges times rate is \$22.50, subtracting deductible leaves \$2.50, 80 percent of \$2.50 is \$2.00. The intermediary would make this computation.)

**Item 23H. Refund to Patient.**—The intermediary will complete this item.

**Item 23I. Net Amount to Agency, G Less H.**—The intermediary will complete this item.

**Certification and Signature Line.**—An agency representative should make sure that the required physician's certification and recertification are in the agency's records. The representative should then sign and date the form before it is submitted to the intermediary. A stamped signature is acceptable. The date forwarded should be the date the bill is actually forwarded to the intermediary; it should not be before the "To" date in the "Statement Covers Period" item.

**405.1 Disposition of Form SSA-1487.**—Retain the copy designated "Home Health Agency Copy" and submit the remaining copies to your intermediary (or SSA in direct dealing situations). The remaining copies to be submitted to the intermediary or SSA are the following:

- a. The original copy which is maintained in the intermediary's (or SSA Direct Reimbursement's) files.
- b. The copy designated "Social Security Administration Copy."

Where the notice of admission copies of the form have not been used for start of care notice purposes they may be discarded.

#### **410. TRANSFER FROM PART A TO PART B HOME HEALTH SERVICES**

If a patient will receive Part B services under the same home health plan of treatment after Part A visits are exhausted, or the time limit for Part A visits has run out, submit separate bills for each part. Do not submit a start of care notice. On the last bill for Part A services, the "still receives services" block in Item 19 is checked.

On the initial bill for Part B services Items 10 and 13 will contain the same dates as on the billings for Part A services.

#### **411. TRANSFER FROM PART B TO PART A HOME HEALTH SERVICES**

If a patient receiving Part B services has a qualifying inpatient stay so that visits under Part A will commence, separate bills must be submitted for each part. The discharge billing for the services under Part B should contain the following information:

**Item 17. "To Date"**—Date of admission to the qualifying hospital or extended care facility stay.

**Item 19. "Discharged"** block should be checked.

**Item 20. "Date applicable to Item 19"**—Date of admission to the qualifying hospital or extended care facility stay.

A start of care notice must be submitted and processed in the usual manner. On the start of care notice and Part A billing complete Items 10, 13, and 17 as follows:

**Item 10.** Show the date on which care started under the Part A plan.

**Item 13.** Show the date on which the new plan for visits under Part A was established.

**Item 17. "From Date"** is the date care started under the Part A plan.

#### **412. EFFECT OF A NEW SPELL OF ILLNESS**

If a patient receiving visits under Part A has an inpatient stay in a qualified institution (see § 112.3), which occurs more than 60 days after his last discharge from an institution which prolongs a spell of illness (see § 112.3), a new spell of illness starts. This terminates the Part A plan of treatment. The agency should prepare a final billing. The "Discharged" block in Item 19 will be checked (and the first day of the inpatient stay entered in Item 20) unless the patient will receive Part B services under the same plan of treatment (see § 410).

If Part A home health visits are resumed after this inpatient stay a new start of care notice is required. If the inpatient stay meets the prior stay requirement (§ 210.2) the new plan will be under Part A, if not, it must be under Part B.

If a patient receiving Part B visits has an inpatient stay which starts a spell of illness and meets the prior stay requirement, § 411 should be followed. If prior stay requirements are not met, Part B visits can continue. In the latter case the information on the inpatient stay should be entered in Items 11 and 12 of the next billing form submitted.

#### **413. MORE THAN ONE AGENCY FURNISHES HOME HEALTH SERVICES**

In the exceptional case where a physician deems it necessary to use two participating home health agencies, the physician will designate the agency which will render the major services and assume the major responsibility for the patient's total care as the primary agency.

Although services can be provided by both agencies, the primary agency will submit the start of care notice, bill for all the services rendered by both agencies to the patient, and keep all the records pertaining to the case including the plan of treatment, required certifications, and the record of the number of visits to be charged against the patient's allowable maximum. The secondary agency will be reimbursed through the primary agency under mutually agreed upon arrangements.

In rare instances a patient is under the care of two physicians, and each physician finds it necessary to establish a home health plan with different agencies to secure required services. Each agency will independently submit a start of care notice and bill for the services it renders.

If it comes to the attention of one home health agency that a patient is receiving services from another agency, each agency providing services to the same patient should, to the extent possible, keep the other agency advised of the visits, etc., furnished by it. This will permit each agency involved to keep track of the number of visits furnished the patient.

#### **415. TRANSFER TO ANOTHER AGENCY UNDER THE SAME HOME HEALTH PLAN OF TREATMENT**

If a patient transfers from one agency to another and the current home health services are a continuation of the original plan of treatment, the first agency will indicate in Item 19 on its final bill that the patient has been "discharged," and insert the day its records are transferred to the other agency in Item 20.

The second agency (after submitting a start of care notice) will bill as though it is the initial provider under that particular plan. The bills will continue to show in Item 10 the original date care was started by the first agency, etc. On the first bill the second agency submits, the billing period in Item 17 will be from the day of the first agency's transfer to the end of the billing period.

#### **420. RENTAL OF DURABLE MEDICAL EQUIPMENT**

The medical insurance program provides coverage for certain enumerated medical and other health services. Under this provision, reimbursement is provided for the rental of durable medical equipment by a provider of services or by an independent supplier to a beneficiary in his place of residence. (See § 208.5 for definition of residence.) Therefore, a home health agency may receive reimbursement on a reasonable cost basis for its rental of durable medical equipment to a Part B beneficiary who is (a) not receiving services under a home health plan of treatment or (b) whose plan has been terminated by his physician because visits are no longer required but who still needs, for example, a wheelchair. The home health billing form, SSA-1487, Item 21K, should be used when requesting reimbursement for the rental of durable medical equipment to a beneficiary who is not under a home health plan of treatment.

If a patient's visits terminate but some piece of equipment is to be rented to the patient, check the block "Still Receives Services" in Item 19 on the final bill for the home health plan of treatment. On billings for the rental of the equipment, use the same entries for Items 10 and 13 as on the earlier billings under the plan of treatment, even though the rental in this instance is not covered as a home health service. These entries are necessary to facilitate computer processing of the rental bill.

If the agency rents equipment to a patient under other conditions than in the paragraph above, a start of care notice must be submitted to facilitate computer processing. The start of care notice and billings should be completed in the usual way except that "Date Care Started" (Item 10) and "Date Home Health Plan Established" (Item 13) should be the first day the equipment is rented.

On the final bill for equipment rental check the "Discharged" block in Item 19.

#### **425. HOME HEALTH SERVICES ARE SUSPENDED OR TERMINATED THEN REINSTATED**

A physician may feel it necessary to suspend visits for a time to determine whether the patient is sufficiently recovered from his condition to do without further home health services. When the suspension is temporary (not more than 60 days) and the physician later determines that the services must be resumed,



the resumed services will be paid under the same program (Part A or Part B) and plan of treatment as before the suspension. No special entry is needed on the bill to indicate a suspension. The date care started (Item 10) and the date plan established (Item 13) will remain the same as on the initial bill. A no-payment bill should not be submitted for the period in which there were no visits.

For purposes of medicare reimbursement, a suspension of home health visits for more than 60 days terminates the plan of treatment. When this occurs, a discharge bill is prepared by the agency. To qualify for additional Part A home health visits, the patient must have a new qualifying inpatient stay, and a new start of care notice must be submitted.

There may also be instances in which a physician determines that home health services being furnished under Part A are no longer necessary and discharges the patient. The physician may later determine that the home health services are again necessary and may establish a plan for services related to the same condition for which the individual was previously hospitalized. However, since the previous plan of treatment was terminated, the subsequent services cannot be paid under Part A unless the patient has had an intervening qualifying inpatient stay. A new start of care notice must be submitted if the patient again qualifies for home health visits.

#### **430. PREPARATION OF A HOME HEALTH BILLING FORM IN NO-PAYMENT SITUATIONS**

Although no payment will be made, a home health billing form should be submitted when:

- a. Workmen's compensation has paid or can be expected to pay the entire bill.
- b. A National Institutes of Health grant paid or will pay the entire bill.
- c. The patient is discharged from home health visits or dies after an earlier bill indicated that he was still receiving services, and no visits have been made during the interim period. In this situation, the date of discharge or death must be later than the "To Date" shown in Item 17 on the earlier bill.

On a no-payment bill, only the following entries should be completed:

- a. Item 1. Patient's name.
- b. Item 2. Health Insurance Claim Number.
- c. Item 7. Provider Number.
- d. Item 10. Date Care Started.
- e. Item 16. Diagnoses and whether illness was employment related.
- f. Item 19. Terminating Action. If Item 19 does not provide the reason for nonpayment, e.g., workmen's compensation, enter reason in open area under Item 22.
- g. Item 20. Date Applicable to Item 19.
- h. Item 21L. Total Charges (this will usually be "None").
- i. Signature of Home Health Agency Representative and Date Forwarded.

**Note:** This abbreviated completion of bills does not apply to two other situations where there will be no reimbursement, i.e., Part B deductible not met, and patient refuses to request payment (§ 401).

#### **440. HOME HEALTH SERVICES UNDER PART B EXTEND FROM ONE CALENDAR YEAR INTO THE FOLLOWING CALENDAR YEAR**

Do not submit a Part B bill for an inclusive period beginning in one calendar year and extending into the following calendar year. If the agency does not normally bill on a calendar month basis, it must prepare two bills. The first will cover the period ending December 31 of the old year, the second, the period beginning January 1 of the new year. This will permit the intermediary to apply the appropriate deductible for both years. A new start of care notice is not required for the period beginning in the new year.

#### **445. PROCEDURES FOR SUBMITTING CORRECTED BILLS**

To correct a previously submitted bill, the home health agency should reproduce a legible copy of the submitted bill. Corrections should be made in red in the appropriate item(s). The corrected bill should be marked "DEBIT-ADJ" in the upper right-hand margin. If all charges and days reported on the previously submitted bill are to be deleted, mark it "CANCEL ONLY" in the upper right-hand margin. Send the corrected bill to the intermediary.



#### 450. EXAMPLES

- I. Initial Billing—Part A Visits.
- II. Subsequent Billing—Part A—Less Than 3-Day Hospital Stay During Billing Period.
- III. Subsequent Billing—Part A—3 (or More) Day Hospital Stay.
- IV. Discharge Billing—Part A—New Spell of Illness.
- V. Initial Billing—Part A—After Transfer From Another Agency.
- VI. Final Billing—Part A—Services Continue but Part A Visits Exhausted.

VII. Initial Billing—Part B—Part A Visits Exhausted.

VIII. Subsequent Billing—Part B—Less Than 3-Day Hospital Stay.

IX. Final Billing—Part B—Patient Qualifies for Part A.

X. Initial Billing—Part A—Equipment Furnished as Home Health Service.

XI. Final Billing—Part A—Physician Terminates Plan—Equipment Still Needed.

XII. Billing for Rental of Equipment—Part B.

## Example I

### I. INITIAL BILLING—PART A—VISITS

John H. Doe has a qualifying inpatient stay April 3, 1967, through April 8, 1967. A home health plan is established April 9, 1967, and care is started on April 10, 1967.

The home health agency submits a start of care notice. The official transfer records furnished this agency contain the inpatient stay dates and are entered in Item 12. The patient's signature is not required since the agency has obtained it on a form maintained in its own records.

The agency receives a reply which indicates (a) the patient is entitled to Part A and Part B, (b) he has 100 visits remaining under both plans, (c) the Part B deductible is met.

The agency charges a unit rate of \$5.00 a visit and the agreed-upon reimbursement rate is 110%. Since the agency has a uniform rate for all services no charges are entered in Items 21A through 21G.

At the end of its monthly billing period the agency submits its billing as below.

DEPARTMENT OF HEALTH, EDUCATION AND WELFARE SOCIAL SECURITY ADMINISTRATION <b>HOME HEALTH AGENCY REPORT AND BILLING</b> HOSPITAL AND MEDICAL INSURANCE BENEFITS—SOCIAL SECURITY ACT										Form Approved Budget Bureau No. No. 72-R736	
1. PATIENT'S LAST NAME <b>Doe</b>			2. FIRST NAME <b>John</b>		3. MI <b>H</b>		4. HEALTH INSURANCE CLAIM NUMBER <b>000-00-0000 A</b>				
5. PATIENT'S ADDRESS (Street number, City, State, Zip Code) <b>6401 Security Blvd., Baltimore, Md. 21235</b>							6. DATE OF BIRTH <b>02 02 29</b>		7. SEX <input checked="" type="checkbox"/> M <input type="checkbox"/> F		
8. HOME HEALTH AGENCY NAME AND ADDRESS <b>X Visiting Nurse Association 110 South Paca St. Baltimore, Md. 21201</b>				9. PROVIDER NO <b>000 000</b>		10. NAME AND ADDRESS OF ATTENDING PHYSICIAN <b>William Jones, M.D. 6401 Uben Blvd. Baltimore, Md. 21201</b>					
11. DATE CARE STARTED <b>04 10 67</b>		12. NAME AND ADDRESS OF INSTITUTION, IF ANY, CARING FOR CONDITION LATER REQUIRING HOME HEALTH SERVICES <b>General Hospital 100 Bruce Street Baltimore, Maryland 21201</b>					13. VERIFIED DATES OF STAY IN ITEM 11 FROM <b>04 03 67</b> TO <b>04 08 67</b>		14. DATE HOME HEALTH PLAN ESTABLISHED <b>04 09 67</b>		
15. PAYMENT SOURCE FOR CHARGES TO PATIENT A <input type="checkbox"/> SELF OR FAMILY    C <input type="checkbox"/> BLUE CROSS    E <input type="checkbox"/> PUBLIC AGENCY B <input type="checkbox"/> PRIVATE INSURANCE    D <input checked="" type="checkbox"/> EMPLOYER OR UNION    F <input type="checkbox"/> OTHER (Explain)											
16. PATIENT'S CERTIFICATION: AUTHORIZATION TO RELEASE INFORMATION AND PAYMENT REQUEST: I certify that the information given by me in applying for payment under Title XVIII of the Social Security Act is correct. I authorize release of all records required to act on this request. I request that payment of authorized benefits be made in my behalf.											
SIGNATURE (Patient or authorized representative) (Signature by mark must be witnessed)										DATE <b>04/09/67</b>	
Patient's Request for Payment on File 17. DIAGNOSES <b>Cerebral Vascular Accident</b> EMPLOYMENT RELATED A <input type="checkbox"/> YES B <input checked="" type="checkbox"/> NO (If yes, give name and address of employer.)											
										LEAVE BLANK	
18. STATEMENT COVERS PERIOD FROM <b>04 10 67</b> TO <b>04 30 67</b>		19. DATE OF FIRST VISIT		20. DATE OF LAST VISIT		21. PATIENT <input type="checkbox"/> DISCHARGED <input type="checkbox"/> DIED <input checked="" type="checkbox"/> STILL RECEIVES SERVICES <input type="checkbox"/> VISITS EXHAUSTED		22. DATE APPLICABLE TO ITEM 19			
23. STATEMENT OF SERVICES RENDERED						24. POST-HOSPITAL PLAN		25. MEDICAL PLAN			
PRIMARY PURPOSE OF VISIT		NO VISITS		CHARGES		NO VISITS		CHARGES			
A. Skilled Nursing Care				\$				\$			
B. Physical Therapy		6									
C. Speech Therapy											
D. Occupational Therapy											
E. Medical Social Services		1									
F. Home Health Aide		1									
G. Other Visits (Specify)											
H. Total No. of Units of Service		8									
I. Charge per unit of Service		\$5.00									
J. TOTALS		8		\$ 40 00							
K. Other (Specify)											
L. TOTAL CHARGES				\$ 40 00							
M. AMOUNT PAID BY PATIENT											
I certify that required physician's certification and recertifications are on file.											
SIGNATURE OF HOME HEALTH AGENCY REPRESENTATIVE <b>/s/ Edward Roberts</b>						DATE FORWARDED <b>05 02 67</b>		APPROVED BY <b>/s/ Joseph Cole</b>			
								DATE APPROVED <b>05 09 67</b>			
FORM SSA-1487 (4-66) HOME HEALTH AGENCY COPY											

## Example II

### II. SUBSEQUENT BILLING—PART A—LESS THAN 3-DAY HOSPITAL STAY DURING BILLING PERIOD

The agency continues visits to the patient during May. However, on May 20, 1967, to May 21, 1967, he is again hospitalized. Although no visits have been made after the hospital discharge, they are expected to continue. At the end of the monthly billing period (May) the agency submits its billing as indicated.

Since this is a subsequent bill only the items indicated

are completed. The dates in Items 10 and 13 are the same as on the prior bill.

Information related to the patient's latest hospital stay is entered in Items 11 and 12.

The hospital stay extends the spell of illness, but does not establish a new 1-year period for Part A visits since it was for less than 3 days.

DEPARTMENT OF HEALTH, EDUCATION AND WELFARE SOCIAL SECURITY ADMINISTRATION <b>HOME HEALTH AGENCY REPORT AND BILLING</b> HOSPITAL AND MEDICAL INSURANCE BENEFITS - SOCIAL SECURITY ACT										Form Approved Budget Bureau No. No. 72-R736	
1. PATIENT'S LAST NAME <b>Doe</b>			FIRST NAME <b>John</b>		MI <b>H</b>	2. HEALTH INSURANCE CLAIM NUMBER <b>000-00-0000 A</b>					
3. PATIENT'S ADDRESS (Street number, City, State, Zip Code) <b>6401 Security Blvd., Baltimore, Md. 21235</b>						4. DATE OF BIRTH ____/____/____		5. SEX <input type="checkbox"/> M <input type="checkbox"/> F			
6. HOME HEALTH AGENCY NAME AND ADDRESS <b>X Visiting Nurse Association 110 South Paca Street Baltimore, Md. 21201</b>				7. PROVIDER NO. <b>000 000</b>		9. NAME AND ADDRESS OF ATTENDING PHYSICIAN					
				8. MEDICAL RECORD NO.							
10. DATE CARE STARTED <b>04   10   67</b>			11. NAME AND ADDRESS OF INSTITUTION, IF ANY, CARING FOR CONDITION LATER REQUIRING HOME HEALTH SERVICES <b>General Hospital 100 Bruce Street Baltimore, Maryland 21201</b>			12. VERIFIED DATES OF STAY IN ITEM 11 FROM <b>05   20   67</b> TO <b>05   21   67</b>		13. DATE HOME HEALTH PLAN ESTABLISHED <b>04   09   67</b>			
14. PAYMENT SOURCE FOR CHARGES TO PATIENT A <input type="checkbox"/> SELF OR FAMILY    C <input type="checkbox"/> BLUE CROSS    E <input type="checkbox"/> PUBLIC AGENCY (Give name) B <input type="checkbox"/> PRIVATE INSURANCE    D <input type="checkbox"/> EMPLOYER OR UNION    F <input type="checkbox"/> OTHER (Explain)											
15. PATIENT'S CERTIFICATION: AUTHORIZATION TO RELEASE INFORMATION AND PAYMENT REQUEST: I certify that the information given by me in applying for payment under Title XVIII of the Social Security Act is correct. I authorize release of all records required to act on this request. I request that payment of authorized benefits be made in my behalf.											
SIGNATURE (Patient or authorized representative) (Signature by mark must be witnessed)									DATE		
16. DIAGNOSES									16. EMPLOYMENT RELATED A <input type="checkbox"/> YES B <input type="checkbox"/> NO (If yes, give name and address of employer.)		
									LEAVE BLANK		
17. STATEMENT COVERS PERIOD FROM <b>05   01   67</b> TO <b>05   31   67</b>		18. DATE OF FIRST VISIT		DATE OF LAST VISIT		19. PATIENT <input type="checkbox"/> DISCHARGED <input checked="" type="checkbox"/> STILL RECEIVES SERVICES <input type="checkbox"/> DIED <input type="checkbox"/> VISITS EXHAUSTED		20. DATE APPLICABLE TO ITEM 19			
21. STATEMENT OF SERVICES RENDERED				POST-HOSPITAL PLAN		MEDICAL PLAN		22. POST-HOSPITAL PLAN			
PRIMARY PURPOSE OF VISIT				NO. VISITS		CHARGES		A. TOTAL CHARGES			
A. Skilled Nursing Care								\$25.00			
B. Physical Therapy				4				B. REIMBURSEMENT RATE			
C. Speech Therapy								110%			
D. Occupational Therapy								C. REIMBURSEMENT AMT A TIMES B			
E. Medical Social Services								27.50			
F. Home Health Aide				1				D. REIMBURSEMENT RATE			
G. Other Visits (Specify)											
H. Total No. of Units of Service				5				E. C TIMES D			
I. Charge per unit of Service \$				5.00				F. E LESS A			
J. TOTALS				5		\$ 25 00		G. REIMBURSEMENT AMT 80% OF F			
K. Other (Specify)								H. REFUND TO PATIENT			
								I. NET AMOUNT TO AGENCY, G LESS H			
L. TOTAL CHARGES						\$ 25 00					
M. AMOUNT PAID BY PATIENT											
I certify that required physician's certification and recertifications are on file. SIGNATURE OF HOME HEALTH AGENCY REPRESENTATIVE <b>/s/ Edward Roberts</b> DATE FORWARDED <b>06   06   67</b> APPROVED BY <b>/s/ Joseph Cole</b> DATE APPROVED <b>06   13   67</b>											

FORM SSA-1487 (4-66)

HOME HEALTH AGENCY COPY



### Example III

## III. SUBSEQUENT BILLING—PART A—3 (OR MORE) DAY HOSPITAL STAY

The patient continues to receive visits. He is rehospitalized from June 10, 1967, to June 17, 1967.

days, the period in which he must use his 100 visits has been extended to June 16, 1968.

Since he was an inpatient for at least 3 consecutive

DEPARTMENT OF HEALTH, EDUCATION, AND WELFARE SOCIAL SECURITY ADMINISTRATION										<b>HOME HEALTH AGENCY REPORT AND BILLING</b> HOSPITAL AND MEDICAL INSURANCE BENEFITS—SOCIAL SECURITY ACT										Form Approved Budget Bureau No. No. 72-R736	
1. PATIENT'S LAST NAME <b>Doe</b>				2. FIRST NAME <b>John</b>		3. MI <b>H</b>		4. HEALTH INSURANCE CLAIM NUMBER <b>000-00-0000 A</b>													
5. PATIENT'S ADDRESS (Street number, City, State, Zip Code) <b>6401 Security Blvd., Baltimore, Md. 21235</b>												6. DATE OF BIRTH ____/____/____		7. SEX <input type="checkbox"/> M <input type="checkbox"/> F							
8. HOME HEALTH AGENCY NAME AND ADDRESS <b>X Visiting Nurse Association 110 South Paca Street Baltimore, Maryland 21201</b>						9. PROVIDER NO. <b>000 000</b>		10. NAME AND ADDRESS OF ATTENDING PHYSICIAN													
11. MEDICAL RECORD NO.																					
12. DATE CARE STARTED <b>06   10   67</b>				13. NAME AND ADDRESS OF INSTITUTION, IF ANY, CARING FOR CONDITION LATER REQUIRING HOME HEALTH SERVICES <b>General Hospital 100 Bruce Street Baltimore, Maryland 21201</b>				14. VERIFIED DATES OF STAY IN ITEM 11 FROM <b>06   10   67</b> TO <b>06   17   67</b>		15. DATE HOME HEALTH PLAN ESTABLISHED <b>06   09   67</b>											
16. PAYMENT SOURCE FOR CHARGES TO PATIENT A. <input type="checkbox"/> SELF OR FAMILY    C. <input type="checkbox"/> BLUE CROSS    E. <input type="checkbox"/> PUBLIC AGENCY (Give name) B. <input type="checkbox"/> PRIVATE INSURANCE    D. <input type="checkbox"/> BLUE SHIELD    F. <input type="checkbox"/> EMPLOYER OR UNION    G. <input type="checkbox"/> OTHER (Explain)																					
17. PATIENT'S CERTIFICATION: AUTHORIZATION TO RELEASE INFORMATION AND PAYMENT REQUEST: I certify that the information given by me in applying for payment under Title XVIII of the Social Security Act is correct. I authorize release of all records required to act on this request. I request that payment of authorized benefits be made in my behalf.																					
18. SIGNATURE (Patient or authorized representative) (Signature by mark must be witnessed)												19. DATE									
20. DIAGNOSES												21. EMPLOYMENT RELATED A. <input type="checkbox"/> YES B. <input type="checkbox"/> NO (If yes, give name and address of employer.)									
LEAVE BLANK																					
22. STATEMENT COVERS PERIOD FROM <b>06   01   67</b> TO <b>06   30   67</b>				23. DATE OF FIRST VISIT				24. DATE OF LAST VISIT				25. PATIENT <input type="checkbox"/> DISCHARGED <input checked="" type="checkbox"/> STILL RECEIVES SERVICES <input type="checkbox"/> DIED <input type="checkbox"/> VISITS EXHAUSTED		26. DATE APPLICABLE TO ITEM 19							
27. STATEMENT OF SERVICES RENDERED																					
28. PRIMARY PURPOSE OF VISIT		29. NO VISITS		30. CHARGES		31. NO VISITS		32. CHARGES		33. A TOTAL CHARGES		34. A VERIFIED DEDUCTIBLE									
A. Skilled Nursing Care		4		\$				\$		\$20.00											
B. Physical Therapy										B REIMBURSEMENT RATE		B VERIFIED COINSURANCE									
C. Speech Therapy										110%											
D. Occupational Therapy										C REIMBURSEMENT AMT. A TIMES B		C. TOTAL CHARGES									
E. Medical Social Services										22.00		D REIMBURSEMENT RATE									
F. Home Health Aide																					
G. Other Visits (Specify)																					
H. Total No. of Units of Service		4										E. C TIMES D									
I. Charge per unit of Service \$		5.00										F. E LESS A									
J. TOTALS		4		\$20.00				\$				G. REIMBURSEMENT AMT 80% OF F									
K. Other (Specify)												H. REFUND TO PATIENT									
L. TOTAL CHARGES				\$20.00				\$				I. NET AMOUNT TO AGENCY, G LESS H									
M. AMOUNT PAID BY PATIENT																					
I certify that required physician's certification and recertifications are on file.																					
19. SIGNATURE OF HOME HEALTH AGENCY REPRESENTATIVE <b>/s/ Edward Roberts</b>						20. DATE FORWARDED <b>07   07   67</b>				21. APPROVED BY <b>/s/ Joseph Cole</b>											
										22. DATE APPROVED <b>07   14   67</b>											
FORM SSA-1487 (4-66) <span style="margin-left: 50px;">HOME HEALTH AGENCY COPY</span>																					

## Example IV

### IV. DISCHARGE BILLING—PART A—NEW SPELL OF ILLNESS

The patient was expected to continue receiving Part A visits although none had been made in August. On August 18, 1967, he was admitted to a qualified hospital. He was discharged from the hospital on August 24, 1967.

A new spell of illness begins because the beneficiary was not an inpatient in the 60 days preceding this pe-

riod of hospitalization. The patient is entitled to a new series of 100 Part A home health visits in the year beginning with his discharge on August 24, 1967.

The agency prepares a discharge bill. Item 17 shows the billing period as August 1, 1967, to August 18, 1967, the date the beneficiary was hospitalized. August 18 is also shown in Item 20.

DEPARTMENT OF HEALTH, EDUCATION, AND WELFARE SOCIAL SECURITY ADMINISTRATION <b>HOME HEALTH AGENCY REPORT AND BILLING</b> HOSPITAL AND MEDICAL INSURANCE BENEFITS—SOCIAL SECURITY ACT										Form Approved Budget Bureau No. No. 72-R736		
1. PATIENT'S LAST NAME <b>Doe</b>			2. FIRST NAME <b>John</b>		3. MI <b>H</b>		4. HEALTH INSURANCE CLAIM NUMBER <b>000-00-0000 A</b>					
5. PATIENT'S ADDRESS (Street number, City, State, Zip Code) <b>6401 Security Blvd., Baltimore, Md. 21235</b>							6. DATE OF BIRTH ____/____/____			7. SEX <input type="checkbox"/> M <input type="checkbox"/> F		
8. HOME HEALTH AGENCY NAME AND ADDRESS <b>X Visiting Nurse Association 110 South Faca St. Baltimore, Md.</b>					9. PROVIDER NO. <b>000 000</b>		10. NAME AND ADDRESS OF ATTENDING PHYSICIAN					
11. MEDICAL RECORD NO.												
12. DATE CARE STARTED <b>08   10   67</b>			13. NAME AND ADDRESS OF INSTITUTION, IF ANY, CARING FOR CONDITION LATER REQUIRING HOME HEALTH SERVICES				14. VERIFIED DATES OF STAY IN ITEM 11 FROM ____ TO ____			15. DATE HOME HEALTH PLAN ESTABLISHED		
16. PAYMENT SOURCE FOR CHARGES TO PATIENT A. <input type="checkbox"/> SELF OR FAMILY    C. <input type="checkbox"/> BLUE CROSS BLUE SHIELD    E. <input type="checkbox"/> PUBLIC AGENCY (Give name) B. <input type="checkbox"/> PRIVATE INSURANCE    D. <input type="checkbox"/> EMPLOYER OR UNION    F. <input type="checkbox"/> OTHER (Explain)												
17. PATIENT'S CERTIFICATION: AUTHORIZATION TO RELEASE INFORMATION AND PAYMENT REQUEST: I certify that the information given by me in applying for payment under Title XVIII of the Social Security Act is correct. I authorize release of all records required to act on this request. I request that payment of authorized benefits be made in my behalf.												
SIGNATURE (Patient or authorized representative) (Signature by mark must be witnessed)										DATE		
18. DIAGNOSES EMPLOYMENT RELATED    A. <input type="checkbox"/> YES    B. <input type="checkbox"/> NO (If yes, give name and address of employer)												
<b>LEAVE BLANK</b>												
19. STATEMENT COVERS PERIOD FROM <b>08   01   67</b> TO <b>08   18   67</b>			20. DATE OF FIRST VISIT			21. DATE OF LAST VISIT			22. PATIENT <input checked="" type="checkbox"/> DISCHARGED <input type="checkbox"/> STILL RECEIVES SERVICES <input type="checkbox"/> DIED <input type="checkbox"/> VISITS EXHAUSTED		23. DATE APPLICABLE TO ITEM 19 <b>08   18   67</b>	
24. STATEMENT OF SERVICES RENDERED				25. POST-HOSPITAL PLAN		26. MEDICAL PLAN		27. POST-HOSPITAL PLAN		28. MEDICAL PLAN		
PRIMARY PURPOSE OF VISIT				NO VISITS		CHARGES		NO VISITS		CHARGES		
A. Skilled Nursing Care						\$				\$		
B. Physical Therapy												
C. Speech Therapy												
D. Occupational Therapy												
E. Medical Social Services												
F. Home Health Aide												
G. Other Visits (Specify)												
H. Total No. of Units of Service												
I. Charge per unit of Service \$												
J. TOTALS						\$				\$		
K. Other (Specify)												
L. TOTAL CHARGES						\$ None				\$		
M. AMOUNT PAID BY PATIENT												
I certify that required physician's certification and recertifications are on file. SIGNATURE OF HOME HEALTH AGENCY REPRESENTATIVE    DATE FORWARDED    APPROVED BY    DATE APPROVED												
/s/ <b>Edward Roberts</b>						<b>08   28   67</b>		/s/ <b>Joseph Cole</b>		<b>08   31   67</b>		
FORM SSA-1487 (4-66) <b>HOME HEALTH AGENCY COPY</b>												

## Example V

### V. INITIAL BILLING—PART A—AFTER TRANSFER FROM ANOTHER AGENCY

On the basis of Mr. Doe's qualifying inpatient stay, August 18, 1967, to August 24, 1967, a new home health plan was established. Visits will now be made by another home health agency.

A new start of care notice shows the plan was established August 25, 1967, and the care started August 26, 1967. The official transfer records furnished this home health agency contain the inpatient stay dates and are

therefore entered in Item 12. The home health agency has the patient sign the SSA-1487.

The home health agency charges on a visit basis but has different rates according to the type of visit. The agreed-upon reimbursement rate is 90%.

On September 14 the agency submits the billing shown below.

DEPARTMENT OF HEALTH, EDUCATION, AND WELFARE SOCIAL SECURITY ADMINISTRATION				<b>HOME HEALTH AGENCY REPORT AND BILLING</b> HOSPITAL AND MEDICAL INSURANCE BENEFITS—SOCIAL SECURITY ACT				Form Approved. Budget Bureau No. No. T2-R736	
1. PATIENT'S LAST NAME <b>Doe</b>		FIRST NAME <b>John</b>		MI <b>H</b>	2. HEALTH INSURANCE CLAIM NUMBER <b>000-00-0000 A</b>				
3. PATIENT'S ADDRESS (Street number, City, State, Zip Code) <b>6401 Security Blvd., Baltimore, Md. 21235</b>					4. DATE OF BIRTH <b>0 9   0 9   9 9</b>		5. SEX <input checked="" type="checkbox"/> M <input type="checkbox"/> F		
6. HOME HEALTH AGENCY NAME AND ADDRESS <b>Neighborhood Nurse Association 425 East 165th, West Baltimore, Md. 21207</b>			7. PROVIDER NO. <b>000 000</b>		9. NAME AND ADDRESS OF ATTENDING PHYSICIAN <b>Paul Taylor, M.D. 101 North Paca Street Baltimore, Md. 21203</b>				
			8. MEDICAL RECORD NO.						
10. DATE CARE STARTED <b>0 8   2 6   6 7</b>		11. NAME AND ADDRESS OF INSTITUTION, IF ANY, CARING FOR CONDITION LATER REQUIRING HOME HEALTH SERVICES <b>Urban Hospital 475 East 165th Street Baltimore, Md. 21207</b>			12. VERIFIED DATES OF STAY IN ITEM 11 FROM <b>08   18   67</b> TO <b>08   24   67</b>		13. DATE HOME HEALTH PLAN ESTABLISHED <b>08   25   67</b>		
14. PAYMENT SOURCE FOR CHARGES TO PATIENT A. <input type="checkbox"/> SELF OR FAMILY    C. <input type="checkbox"/> BLUE CROSS BLUE SHIELD    E. <input type="checkbox"/> PUBLIC AGENCY (Give name) B. <input type="checkbox"/> PRIVATE INSURANCE    D. <input checked="" type="checkbox"/> EMPLOYER OR UNION    F. <input type="checkbox"/> OTHER (Explain)									
15. PATIENT'S CERTIFICATION: AUTHORIZATION TO RELEASE INFORMATION AND PAYMENT REQUEST: I certify that the information given by me in applying for payment under Title XVIII of the Social Security Act is correct. I authorize release of all records required to act on this request. I request that payment of authorized benefits be made in my behalf.									
SIGNATURE (Patient or authorized representative) (Signature by mark must be witnessed)							DATE		
/s/ <b>John H. Doe</b>							<b>08/26/67</b>		
16. DIAGNOSES  <b>Cerebral Vascular Accident</b>				EMPLOYMENT RELATED    A. <input type="checkbox"/> YES    B. <input checked="" type="checkbox"/> NO (If yes, give name and address of employer)		LEAVE BLANK			
17. STATEMENT COVERS PERIOD FROM <b>08   26   67</b> TO <b>08   31   67</b>		18. DATE OF FIRST VISIT		DATE OF LAST VISIT		19. PATIENT <input type="checkbox"/> DISCHARGED <input checked="" type="checkbox"/> STILL RECEIVES SERVICES <input type="checkbox"/> DIED <input type="checkbox"/> VISITS EXHAUSTED		20. DATE APPLICABLE TO ITEM 19	
21. STATEMENT OF SERVICES RENDERED				POST-HOSPITAL PLAN		MEDICAL PLAN		22. POST-HOSPITAL PLAN	
PRIMARY PURPOSE OF VISIT		NO VISITS		CHARGES		NO VISITS		CHARGES	
A. Skilled Nursing Care								A. TOTAL CHARGES <b>\$30.00</b>	
B. Physical Therapy		<b>2</b>		<b>20 00</b>				B. REIMBURSEMENT RATE <b>90%</b>	
C. Speech Therapy								C. REIMBURSEMENT AMT A TIMES B <b>27.00</b>	
D. Occupational Therapy								C TOTAL CHARGES	
E. Medical Social Services		<b>1</b>		<b>6 00</b>				D REIMBURSEMENT RATE	
F. Home Health Aide		<b>1</b>		<b>4 00</b>				E C TIMES D	
G. Other Visits (Specify)								F E LESS A	
H. Total No. of Units of Service								G REIMBURSEMENT AMT 80 % OF F	
I. Charge per unit of Service \$								H REFUND TO PATIENT	
J. TOTALS		<b>4</b>		<b>\$ 30 00</b>				I NET AMOUNT TO AGENCY, G LESS H	
K. Other (Specify)									
L. TOTAL CHARGES				<b>\$ 30 00</b>					
M. AMOUNT PAID BY PATIENT									
I certify that required physician's certification and recertifications are on file.									
SIGNATURE OF HOME HEALTH AGENCY REPRESENTATIVE <b>/s/ Henry Daly</b>				DATE FORWARDED <b>0 9   1 4   6 7</b>		APPROVED BY <b>/s/ Thomas Sides</b>		DATE APPROVED <b>0 9   2 5   6 7</b>	
FORM SSA-1487 (4-66)      HOME HEALTH AGENCY COPY									



## Example VI

### VI. FINAL BILLING—PART A—SERVICES CONTINUE BUT PART A VISITS EXHAUSTED

Mr. Doe receives Part A home health visits until March 15, 1968, when the 100 visits are exhausted. The home health agency now transfers him to Part B visits.

The agency must submit two bills for the month of

March, one for the Part A visits and one for the Part B visits.

This example VI shows the information to be entered on the Part A bill.

See Example VII for the Part B bill.

DEPARTMENT OF HEALTH, EDUCATION, AND WELFARE SOCIAL SECURITY ADMINISTRATION <b>HOME HEALTH AGENCY REPORT AND BILLING</b> <b>HOSPITAL AND MEDICAL INSURANCE BENEFITS - SOCIAL SECURITY ACT</b>										Form Approved Budget Bureau No. No. 72-R736	
1. PATIENT'S LAST NAME <b>Doe</b>			2. FIRST NAME <b>John</b>		3. MI <b>H</b>		4. HEALTH INSURANCE CLAIM NUMBER <b>000-00-0000 A</b>				
5. PATIENT'S ADDRESS (Street number, City, State, Zip Code) <b>6401 Security Blvd., Baltimore, Md. 21235</b>							6. DATE OF BIRTH ____/____/____		7. SEX <input type="checkbox"/> M <input type="checkbox"/> F		
8. HOME HEALTH AGENCY NAME AND ADDRESS <b>Neighborhood Nurse Association 425 East 165th, West Baltimore, Md. 21207</b>							9. PROVIDER NO. <b>000 000</b>		10. NAME AND ADDRESS OF ATTENDING PHYSICIAN		
							11. MEDICAL RECORD NO.				
12. DATE CARE STARTED <b>08   26   67</b>		13. NAME AND ADDRESS OF INSTITUTION, IF ANY, CARING FOR CONDITION LATER REQUIRING HOME HEALTH SERVICES					14. VERIFIED DATES OF STAY IN ITEM 11 FROM ____ TO ____		15. DATE HOME HEALTH PLAN ESTABLISHED <b>08   25   67</b>		
16. PAYMENT SOURCE FOR CHARGES TO PATIENT A <input type="checkbox"/> SELF OR FAMILY C <input type="checkbox"/> BLUE CROSS BLUE SHIELD E <input type="checkbox"/> PUBLIC AGENCY (Give name) B <input type="checkbox"/> PRIVATE INSURANCE D <input type="checkbox"/> EMPLOYER OR UNION F <input type="checkbox"/> OTHER (Explain)											
17. PATIENT'S CERTIFICATION: AUTHORIZATION TO RELEASE INFORMATION AND PAYMENT REQUEST: I certify that the information given by me in applying for payment under Title XVIII of the Social Security Act is correct. I authorize release of all records required to act on this request. I request that payment of authorized benefits be made in my behalf.											
18. SIGNATURE (Patient or authorized representative) (Signature by mark must be witnessed)										19. DATE	
20. DIAGNOSES											
21. EMPLOYMENT RELATED A <input type="checkbox"/> YES B <input type="checkbox"/> NO (If yes, give name and address of employer.)										22. LEAVE BLANK	
23. STATEMENT COVERS PERIOD FROM <b>03   01   68</b> TO <b>03   15   68</b>		24. DATE OF FIRST VISIT		25. DATE OF LAST VISIT		26. PATIENT <input type="checkbox"/> DISCHARGED <input checked="" type="checkbox"/> STILL RECEIVES SERVICES <input type="checkbox"/> DIED <input type="checkbox"/> VISITS EXHAUSTED		27. DATE APPLICABLE TO ITEM 19			
28. STATEMENT OF SERVICES RENDERED				29. POST-HOSPITAL PLAN		30. MEDICAL PLAN		31. POST-HOSPITAL PLAN		32. MEDICAL PLAN	
PRIMARY PURPOSE OF VISIT				NO. VISITS		CHARGES		NO. VISITS		CHARGES	
A. Skilled Nursing Care				4		\$ 40.00					
B. Physical Therapy											
C. Speech Therapy											
D. Occupational Therapy											
E. Medical Social Services											
F. Home Health Aide											
G. Other Visits (Specify)											
H. Total No. of Units of Service											
I. Charge per unit of Service \$											
J. TOTALS				4		\$ 40.00					
K. Other (Specify)											
L. TOTAL CHARGES						\$ 40.00					
M. AMOUNT PAID BY PATIENT											
I certify that required physician's certification and recertifications are on file											
SIGNATURE OF HOME HEALTH AGENCY REPRESENTATIVE <b>/s/ Henry Daly</b>				DATE FORWARDED <b>03   20   68</b>		APPROVED BY <b>/s/ Thomas Sides</b>		DATE APPROVED <b>03   28   68</b>			
FORM SSA-1487 (4-66) <span style="margin-left: 50px;">HOME HEALTH AGENCY COPY</span>											

## Example VII

### VII. INITIAL BILLING—PART B—PART A VISITS EXHAUSTED

This example is the bill for Part B visits in March 1968.

The agency believes no part of the \$50 Part B deductible has been met and prematurely collects the total charge of \$40 from the patient. It does not complete Item 23 of the billing form, which the agency completes only when it knows the deductible has been met.

On receipt of the Part B bill for March 1968, the

intermediary queries the SSA central record for deductible status. The reply shows \$30 remaining to meet the Part B deductible for 1968.

The intermediary completes Item 23 to compute the reimbursement amount. A refund of \$8 is determined to be due the patient. The agency has been overpaid \$3.20. This will be adjusted when the agency submits another bill. The intermediary makes the refund to the patient.

DEPARTMENT OF HEALTH, EDUCATION AND WELFARE SOCIAL SECURITY ADMINISTRATION <b>HOME HEALTH AGENCY REPORT AND BILLING</b> HOSPITAL AND MEDICAL INSURANCE BENEFITS—SOCIAL SECURITY ACT										Form Approved Budget Bureau No. No. 72-R736	
1. PATIENT'S LAST NAME <b>Doe</b>			2. FIRST NAME <b>John</b>		3. MI <b>H</b>	4. HEALTH INSURANCE CLAIM NUMBER <b>000-00-0000 A</b>					
5. PATIENT'S ADDRESS (Street number, City, State, Zip Code) <b>6401 Security Blvd., Baltimore, Md. 21235</b>						6. DATE OF BIRTH ____/____/____		7. SEX <input type="checkbox"/> M <input type="checkbox"/> F			
8. HOME HEALTH AGENCY NAME AND ADDRESS <b>Neighborhood Nurse Association 425 East 165th, West Baltimore, Md. 21207</b>				9. PROVIDER NO. <b>000 000</b>		10. NAME AND ADDRESS OF ATTENDING PHYSICIAN					
11. MEDICAL RECORD NO.				12. VERIFIED DATES OF STAY IN ITEM 11 FROM ____/____/____ TO ____/____/____				13. DATE HOME HEALTH PLAN ESTABLISHED <b>08 25 67</b>			
14. DATE CARE STARTED <b>08 26 67</b>		15. NAME AND ADDRESS OF INSTITUTION, IF ANY, CARING FOR CONDITION LATER REQUIRING HOME HEALTH SERVICES									
16. PAYMENT SOURCE FOR CHARGES TO PATIENT A. <input type="checkbox"/> SELF OR FAMILY    C. <input type="checkbox"/> BLUE CROSS BLUE SHIELD    E. <input type="checkbox"/> PUBLIC AGENCY (Give name) B. <input type="checkbox"/> PRIVATE INSURANCE    D. <input type="checkbox"/> EMPLOYER OR UNION    F. <input type="checkbox"/> OTHER (Explain)											
17. PATIENT'S CERTIFICATION: AUTHORIZATION TO RELEASE INFORMATION AND PAYMENT REQUEST: I certify that the information given by me in applying for payment under Title XVIII of the Social Security Act is correct. I authorize release of all records required to act on this request. I request that payment of authorized benefits be made in my behalf.											
SIGNATURE (Patient or authorized representative) (Signature by mark must be witnessed)								DATE			
18. DIAGNOSES EMPLOYMENT RELATED    A. <input type="checkbox"/> YES    B. <input type="checkbox"/> NO    (If yes, give name and address of employer)											
LEAVE BLANK											
19. STATEMENT COVERS PERIOD FROM <b>03 16 68</b> TO <b>03 31 68</b>		20. DATE OF FIRST VISIT		21. DATE OF LAST VISIT		22. PATIENT <input type="checkbox"/> DISCHARGED <input checked="" type="checkbox"/> STILL RECEIVES SERVICES <input type="checkbox"/> DIED <input type="checkbox"/> VISITS EXHAUSTED		23. DATE APPLICABLE TO ITEM 19			
24. STATEMENT OF SERVICES RENDERED		25. POST-HOSPITAL PLAN		26. MEDICAL PLAN		27. POST-HOSPITAL PLAN		28. MEDICAL PLAN			
PRIMARY PURPOSE OF VISIT		NO VISITS		CHARGES		NO VISITS		CHARGES			
A. Skilled Nursing Care				\$				\$			
B. Physical Therapy						3		30 00			
C. Speech Therapy											
D. Occupational Therapy											
E. Medical Social Services											
F. Home Health Aide						1		6 00			
G. Other Visits (Specify) <b>Intern</b>						1		4 00			
H. Total No. of Units of Service											
I. Charge per unit of Service \$											
J. TOTALS				\$		5		\$ 40 00			
K. Other (Specify)											
L. TOTAL CHARGES				\$				\$ 40 00			
M. AMOUNT PAID BY PATIENT								\$ 40 00			
I certify that required physician's certification and recertifications are on file.											
SIGNATURE OF HOME HEALTH AGENCY REPRESENTATIVE <b>/s/ Henry Daly</b>				DATE FORWARDED <b>04 01 68</b>		APPROVED BY <b>/s/ Thomas Sides</b>		DATE APPROVED <b>04 12 68</b>			
FORM SSA-1487 14-661 <b>HOME HEALTH AGENCY COPY</b>											

## VIII. SUBSEQUENT BILLING—PART B—LESS THAN 3-DAY HOSPITAL STAY

stay is entered in Items 11 and 12 of the next bill.

Since the agency now knows that the Part B deductible was met by its last bill, it may complete Item 23 on this bill.

Revision No. 4  
10/67



## Example IX

### IX. FINAL BILLING—PART B—PATIENT QUALIFIES FOR PART A

From July 4, 1968, to July 8, 1968, Mr. Doe receives inpatient services in a nonparticipating hospital which meets all the conditions of participation. Since a spell of illness started as a result of the June hospitalization, this inpatient stay of 4 days entitles him to a new 100 Part A visits. A new plan must be established.

This example is the final Part B bill. The "To" date

in Item 17 is the same date as shown in Item 20, i.e., the date of admission to the hospital.

Information has also been received by the agency that the Department of Welfare will pay for charges to the patient. The name and address of the agency as well as the case number assigned to the patient are shown in Item 14.

DEPARTMENT OF HEALTH, EDUCATION, AND WELFARE SOCIAL SECURITY ADMINISTRATION <b>HOME HEALTH AGENCY REPORT AND BILLING</b> HOSPITAL AND MEDICAL INSURANCE BENEFITS—SOCIAL SECURITY ACT										Form Approved Budget Bureau No. No. 72-R736																																																																	
1. PATIENT'S LAST NAME <b>Doe</b>			2. FIRST NAME <b>John</b>		3. MI <b>H</b>		4. HEALTH INSURANCE CLAIM NUMBER <b>000-00-0000 A</b>																																																																				
5. PATIENT'S ADDRESS (Street number, City, State, Zip Code) <b>6401 Security Blvd., Baltimore, Md. 21235</b>							6. DATE OF BIRTH ____/____/____			7. SEX <input type="checkbox"/> M <input type="checkbox"/> F																																																																	
8. HOME HEALTH AGENCY NAME AND ADDRESS <b>Neighborhood Nurse Association 425 East 165th, West Baltimore, Md. 21207</b>				9. PROVIDER NO. <b>000 000</b>		10. NAME AND ADDRESS OF ATTENDING PHYSICIAN																																																																					
11. MEDICAL RECORD NO.				12. VERIFIED DATES OF STAY IN ITEM 11 FROM ____ TO ____				13. DATE HOME HEALTH PLAN ESTABLISHED <b>08 25 67</b>																																																																			
14. DATE CARE STARTED <b>0 8 2 6 6 7</b>		15. NAME AND ADDRESS OF INSTITUTION, IF ANY, CARING FOR CONDITION LATER REQUIRING HOME HEALTH SERVICES						16. DATE																																																																			
17. PAYMENT SOURCE FOR CHARGES TO PATIENT A. <input type="checkbox"/> SELF OR FAMILY    C. <input type="checkbox"/> BLUE CROSS    E. <input checked="" type="checkbox"/> PUBLIC AGENCY (Give name) B. <input type="checkbox"/> PRIVATE INSURANCE    D. <input type="checkbox"/> EMPLOYER OR UNION    F. <input type="checkbox"/> OTHER (Explain) <b>Department of Welfare 702 Main Street Baltimore, Maryland 21209 Case No. 66464</b>																																																																											
18. PATIENT'S CERTIFICATION: AUTHORIZATION TO RELEASE INFORMATION AND PAYMENT REQUEST: I certify that the information given by me in applying for payment under Title XVIII of the Social Security Act is correct. I authorize release of all records required to act on this request. I request that payment of authorized benefits be made in my behalf.																																																																											
SIGNATURE (Patient or authorized representative) (Signature by mark must be witnessed)										DATE																																																																	
19. DIAGNOSES EMPLOYMENT RELATED    A. <input type="checkbox"/> YES    B. <input type="checkbox"/> NO (If yes, give name and address of employer.) <b>LEAVE BLANK</b>																																																																											
20. STATEMENT COVERS PERIOD FROM <b>07 01 68</b> TO <b>07 04 68</b>		21. DATE OF FIRST VISIT		22. DATE OF LAST VISIT		23. PATIENT <input checked="" type="checkbox"/> DIS-CHARGED <input type="checkbox"/> STILL RECEIVES SERVICES <input type="checkbox"/> DIED <input type="checkbox"/> VISITS EXHAUSTED		24. DATE APPLICABLE TO ITEM 19 <b>0 7 0 4 6 8</b>																																																																			
25. STATEMENT OF SERVICES RENDERED				26. POST-HOSPITAL PLAN		27. MEDICAL PLAN		28. POST-HOSPITAL PLAN		29. MEDICAL PLAN																																																																	
<table border="1" style="width: 100%; border-collapse: collapse;"> <thead> <tr> <th>PRIMARY PURPOSE OF VISIT</th> <th>NO. VISITS</th> <th>CHARGES</th> <th>NO. VISITS</th> <th>CHARGES</th> </tr> </thead> <tbody> <tr> <td>A. Skilled Nursing Care</td> <td></td> <td>\$</td> <td></td> <td>\$</td> </tr> <tr> <td>B. Physical Therapy</td> <td></td> <td></td> <td>1</td> <td>10.00</td> </tr> <tr> <td>C. Speech Therapy</td> <td></td> <td></td> <td></td> <td></td> </tr> <tr> <td>D. Occupational Therapy</td> <td></td> <td></td> <td></td> <td></td> </tr> <tr> <td>E. Medical Social Services</td> <td></td> <td></td> <td></td> <td></td> </tr> <tr> <td>F. Home Health Aide</td> <td></td> <td></td> <td>1</td> <td>4.00</td> </tr> <tr> <td>G. Other Visits (Specify)</td> <td></td> <td></td> <td></td> <td></td> </tr> <tr> <td>H. Total No. of Units of Service</td> <td></td> <td></td> <td></td> <td></td> </tr> <tr> <td>I. Charge per unit of Service \$</td> <td></td> <td></td> <td></td> <td></td> </tr> <tr> <td>J. TOTALS</td> <td></td> <td>\$</td> <td>2</td> <td>\$ 14.00</td> </tr> <tr> <td>K. Other (Specify)</td> <td></td> <td></td> <td></td> <td></td> </tr> <tr> <td>L. TOTAL CHARGES</td> <td></td> <td>\$</td> <td></td> <td>\$ 14.00</td> </tr> <tr> <td>M. AMOUNT PAID BY PATIENT</td> <td></td> <td>\$</td> <td></td> <td></td> </tr> </tbody> </table>				PRIMARY PURPOSE OF VISIT	NO. VISITS	CHARGES	NO. VISITS	CHARGES	A. Skilled Nursing Care		\$		\$	B. Physical Therapy			1	10.00	C. Speech Therapy					D. Occupational Therapy					E. Medical Social Services					F. Home Health Aide			1	4.00	G. Other Visits (Specify)					H. Total No. of Units of Service					I. Charge per unit of Service \$					J. TOTALS		\$	2	\$ 14.00	K. Other (Specify)					L. TOTAL CHARGES		\$		\$ 14.00	M. AMOUNT PAID BY PATIENT		\$			30. A. TOTAL CHARGES <b>0</b> B. REIMBURSEMENT RATE <b>\$ 2.80</b> C. REIMBURSEMENT AMT A TIMES B <b>14.00</b> D. REIMBURSEMENT RATE <b>90%</b> E. C TIMES D <b>12.60</b> F. E LESS A <b>12.60</b> G. REIMBURSEMENT AMT 80% OF F <b>10.08</b> H. REFUND TO PATIENT <b>0</b> I. NET AMOUNT TO AGENCY, G LESS H <b>\$10.08</b>	
PRIMARY PURPOSE OF VISIT	NO. VISITS	CHARGES	NO. VISITS	CHARGES																																																																							
A. Skilled Nursing Care		\$		\$																																																																							
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M. AMOUNT PAID BY PATIENT		\$																																																																									
I certify that required physician's certification and recertifications are on file. SIGNATURE OF HOME HEALTH AGENCY REPRESENTATIVE <b>/s/ Henry Daly</b>						DATE FORWARDED <b>0 7 0 6 6 8</b>		APPROVED BY <b>/s/ Thomas Sides</b>		DATE APPROVED <b>0 7 1 6 6 8</b>																																																																	
FORM SSA-1487 (4-66)    HOME HEALTH AGENCY COPY																																																																											

## Example X

### X. INITIAL BILLING—PART A—EQUIPMENT FURNISHED AS HOME HEALTH SERVICE

This is the initial Part A bill following the final Part B bill in Example IX. The agency submitted a start of care notice.

A Part A plan was established July 20, 1968, and care started July 21, 1968.

The home health agency, in addition to visits, is now

furnishing a wheelchair to the patient. This is billed for in Item 21K.

Since services are now being furnished under a new home health plan, a new request for payment is required. The patient's signature has been obtained on the agency's record.

DEPARTMENT OF HEALTH, EDUCATION, AND WELFARE SOCIAL SECURITY ADMINISTRATION <b>HOME HEALTH AGENCY REPORT AND BILLING</b> <b>HOSPITAL AND MEDICAL INSURANCE BENEFITS—SOCIAL SECURITY ACT</b>										Form Approved Budget Bureau No. No. 72-R736																																																																												
1. PATIENT'S LAST NAME <b>Doa</b>			2. FIRST NAME <b>John</b>			3. MI <b>H</b>		4. HEALTH INSURANCE CLAIM NUMBER <b>000-00-0000 A</b>																																																																														
5. PATIENT'S ADDRESS (Street number, City, State, Zip Code) <b>6401 Security Blvd., Baltimore, Md. 21235</b>						6. DATE OF BIRTH <b>09   09   99</b>		7. SEX <input checked="" type="checkbox"/> M <input type="checkbox"/> F																																																																														
8. HOME HEALTH AGENCY NAME AND ADDRESS <b>Neighborhood Nurse Association 425 East 165th, West Baltimore, Md. 21207</b>				9. PROVIDER NO. <b>000 000</b>		10. NAME AND ADDRESS OF ATTENDING PHYSICIAN <b>Harold Burns, M.D. 716 West 65 Street Baltimore, Md. 21209</b>																																																																																
11. MEDICAL RECORD NO.																																																																																						
12. DATE CARE STARTED <b>07   21   68</b>			13. NAME AND ADDRESS OF INSTITUTION, IF ANY, CARING FOR CONDITION LATER REQUIRING HOME HEALTH SERVICES <b>XYZ Hospital Bruce Street Baltimore, Md. 21209</b>				14. VERIFIED DATES OF STAY IN ITEM 11 FROM <b>07   04   68</b> TO <b>07   08   68</b>		15. DATE HOME HEALTH PLAN ESTABLISHED <b>07   20   68</b>																																																																													
16. PAYMENT SOURCE FOR CHARGES TO PATIENT										17. CASE NO. <b>66464</b>																																																																												
A. <input type="checkbox"/> SELF OR FAMILY C. <input type="checkbox"/> BLUE CROSS E. <input checked="" type="checkbox"/> PUBLIC AGENCY (Give name) B. <input type="checkbox"/> PRIVATE INSURANCE D. <input type="checkbox"/> EMPLOYER OR UNION F. <input type="checkbox"/> OTHER (Explain) <b>Department of Welfare 702 Main St. Baltimore, Maryland 21209</b>																																																																																						
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19. SIGNATURE (Patient or authorized representative) (Signature by mark must be witnessed) <b>Patient request for payment on file</b>										20. DATE <b>7/20/68</b>																																																																												
21. DIAGNOSES <b>Cerebral Vascular Accident</b>																																																																																						
22. EMPLOYMENT RELATED A. <input type="checkbox"/> YES B. <input checked="" type="checkbox"/> NO (If yes, give name and address of employer.)																																																																																						
23. STATEMENT COVERS PERIOD FROM <b>07   21   68</b> TO <b>07   31   68</b>																																																																																						
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PRIMARY PURPOSE OF VISIT	NO VISITS	CHARGES	NO VISITS	CHARGES																																																																																		
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33. SIGNATURE OF HOME HEALTH AGENCY REPRESENTATIVE <b>/s/ Henry Daly</b>						34. DATE FORWARDED <b>08   02   68</b>		35. APPROVED BY <b>/s/ Thomas Sidez</b>		36. DATE APPROVED <b>08   12   68</b>																																																																												
FORM SSA-1487 (4-65) HOME HEALTH AGENCY COPY																																																																																						

## Example XI

### XI. FINAL BILLING—PART A—PHYSICIAN TERMINATES PLAN—EQUIPMENT STILL NEEDED

On March 9, 1969, the patient's physician decides that visits are no longer necessary. However, the wheelchair will still be required.

The home health agency will rent the patient the wheelchair after March 9, 1969.

This example shows the last Part A billing form for services to March 9, 1969.

DEPARTMENT OF HEALTH, EDUCATION, AND WELFARE SOCIAL SECURITY ADMINISTRATION <b>HOME HEALTH AGENCY REPORT AND BILLING</b> HOSPITAL AND MEDICAL INSURANCE BENEFITS—SOCIAL SECURITY ACT										Form Approved Budget Bureau No. No. 72-R738	
1. PATIENT'S LAST NAME <b>Doe</b>		FIRST NAME <b>John</b>		MI <b>H</b>	2. HEALTH INSURANCE CLAIM NUMBER <b>000-00-0000 A</b>					5. SEX <input type="checkbox"/> M <input type="checkbox"/> F	
3. PATIENT'S ADDRESS (Street number, City, State, Zip Code) <b>6401 Security Blvd., Baltimore, Md. 21235</b>					4. DATE OF BIRTH ____/____/____						
6. HOME HEALTH AGENCY NAME AND ADDRESS <b>Neighborhood Nurse Association 425 East 165th, West Baltimore, Md. 21207</b>					7. PROVIDER NO. <b>000 000</b>		9. NAME AND ADDRESS OF ATTENDING PHYSICIAN				
					8. MEDICAL RECORD NO.						
10. DATE CARE STARTED <b>07   21   68</b>		11. NAME AND ADDRESS OF INSTITUTION, IF ANY, CARING FOR CONDITION LATER REQUIRING HOME HEALTH SERVICES					12. VERIFIED DATES OF STAY IN ITEM 11 FROM ____ TO ____		13. DATE HOME HEALTH PLAN ESTABLISHED <b>07   20   68</b>		
14. PAYMENT SOURCE FOR CHARGES TO PATIENT A. <input type="checkbox"/> SELF OR FAMILY    C. <input type="checkbox"/> BLUE CROSS BLUE SHIELD    E. <input type="checkbox"/> PUBLIC AGENCY (Give name) B. <input type="checkbox"/> PRIVATE INSURANCE    D. <input type="checkbox"/> EMPLOYER OR UNION    F. <input type="checkbox"/> OTHER (Explain)											
15. PATIENT'S CERTIFICATION: AUTHORIZATION TO RELEASE INFORMATION AND PAYMENT REQUEST: I certify that the information given by me in applying for payment under Title XVIII of the Social Security Act is correct. I authorize release of all records required to act on this request. I request that payment of authorized benefits be made in my behalf.											
SIGNATURE (Patient or authorized representative) (Signature by mark must be witnessed)										DATE	
16. DIAGNOSES EMPLOYMENT RELATED    A. <input type="checkbox"/> YES    B. <input type="checkbox"/> NO    (If yes, give name and address of employer.) LEAVE BLANK											
17. STATEMENT COVERS PERIOD FROM <b>03   01   69</b> TO <b>03   09   69</b>		18. DATE OF FIRST VISIT		DATE OF LAST VISIT		19. PATIENT <input type="checkbox"/> DIS-CHARGED <input checked="" type="checkbox"/> STILL RECEIVES SERVICES <input type="checkbox"/> DIED <input type="checkbox"/> VISITS EXHAUSTED		20. DATE APPLICABLE TO ITEM 19			
21. STATEMENT OF SERVICES RENDERED			POST-HOSPITAL PLAN		MEDICAL PLAN		POST-HOSPITAL PLAN		23. MEDICAL PLAN		
PRIMARY PURPOSE OF VISIT			NO VISITS	CHARGES	NO VISITS	CHARGES	A. TOTAL CHARGES		A. VERIFIED DEDUCTIBLE		
A. Skilled Nursing Care			2	\$ 20.00		\$	\$45.00				
B. Physical Therapy							B. REIMBURSEMENT RATE		B. VERIFIED COINSURANCE		
C. Speech Therapy			1	10.00			90%				
D. Occupational Therapy			1	6.00			C. REIMBURSEMENT AMT A TIMES B		C. TOTAL CHARGES		
E. Medical Social Services							\$40.50		D. REIMBURSEMENT RATE		
F. Home Health Aide									E. C TIMES D		
G. Other Visits (Specify)									F. E LESS A		
H. Total No. of Units of Service									G. REIMBURSEMENT AMT 80% OF F		
I. Charge per unit of Service \$									H. REFUND TO PATIENT		
J. TOTALS			4	\$ 36.00		\$			I. NET AMOUNT TO AGENCY, G LESS H		
K. Other (Specify)											
Wheel chair				9.00							
L. TOTAL CHARGES				\$ 45.00		\$					
M. AMOUNT PAID BY PATIENT						\$					
I certify that required physician's certification and recertifications are on file.											
SIGNATURE OF HOME HEALTH AGENCY REPRESENTATIVE <b>/s/ Henry Daly</b>					DATE FORWARDED <b>03   18   69</b>		APPROVED BY <b>/s/ Thomas Sides</b>		DATE APPROVED <b>03   27   69</b>		
FORM SSA-1487 (4-66) <span style="float: right;">HOME HEALTH AGENCY COPY</span>											



## Example XII

### XII. BILLING FOR RENTAL OF EQUIPMENT—PART B

On March 10, 1969, the rental of the wheelchair takes effect. The rental of durable medical equipment is reimbursable on a cost basis under Part B. This example shows the billing form for the period March 10, 1969, through March 31, 1969.

**Note:** While the rental of durable medical equipment is not reimbursable when the patient is under a home health plan of treatment, Items 10 and 13 must be completed to facilitate computer processing by the Social Security Administration. The dates shown on the last bill are therefore repeated on this bill. Item 19 shows "still receives services" for the same reason.

Since the agency does not know whether the Part B deductible has been met for 1969, it does not complete Item 23.

On receipt of the bill the intermediary queries to SSA central record for the patient's 1969 deductible status. The reply indicates that \$16 of the deductible remains to be met. The intermediary completes Item 23 to compute the reimbursement amount due the agency. The intermediary informs the agency of the deductible and coinsurance amounts for which the patient is liable.

DEPARTMENT OF HEALTH, EDUCATION, AND WELFARE SOCIAL SECURITY ADMINISTRATION <b>HOME HEALTH AGENCY REPORT AND BILLING</b> HOSPITAL AND MEDICAL INSURANCE BENEFITS—SOCIAL SECURITY ACT										Form Approved, Budget Bureau No. No. 72-R736	
1. PATIENT'S LAST NAME <b>Doe</b>			2. FIRST NAME <b>John</b>			3. MI <b>H</b>		4. HEALTH INSURANCE CLAIM NUMBER <b>000-00-0000 A</b>			
5. PATIENT'S ADDRESS (Street number, City, State, Zip Code) <b>6401 Security Blvd., Baltimore, Md. 21235</b>						6. DATE OF BIRTH		7. SEX <input type="checkbox"/> M <input type="checkbox"/> F			
8. HOME HEALTH AGENCY NAME AND ADDRESS <b>Neighborhood Nurse Association 425 East 165th, West Baltimore, Md. 21235</b>						9. PROVIDER NO. <b>000 000</b>		10. NAME AND ADDRESS OF ATTENDING PHYSICIAN			
11. MEDICAL RECORD NO.						12. VERIFIED DATES OF STAY IN ITEM 11 FROM: TO:			13. DATE HOME HEALTH PLAN ESTABLISHED <b>07   20   68</b>		
14. DATE CARE STARTED <b>07   21   68</b>			15. NAME AND ADDRESS OF INSTITUTION, IF ANY, CARING FOR CONDITION LATER REQUIRING HOME HEALTH SERVICES			16. VERIFIED DATES OF STAY IN ITEM 11 FROM: TO:			17. DATE HOME HEALTH PLAN ESTABLISHED <b>07   20   68</b>		
18. PAYMENT SOURCE FOR CHARGES TO PATIENT A. <input type="checkbox"/> SELF OR FAMILY    C. <input type="checkbox"/> BLUE CROSS BLUE SHIELD    E. <input type="checkbox"/> PUBLIC AGENCY (Give name) B. <input type="checkbox"/> PRIVATE INSURANCE    D. <input type="checkbox"/> EMPLOYER OR UNION    F. <input type="checkbox"/> OTHER (Explain)											
19. PATIENT'S CERTIFICATION: AUTHORIZATION TO RELEASE INFORMATION AND PAYMENT REQUEST: I certify that the information given by me in applying for payment under Title XVIII of the Social Security Act is correct. I authorize release of all records required to act on this request. I request that payment of authorized benefits be made in my behalf.											
SIGNATURE (Patient or authorized representative) (Signature by mark must be witnessed)										DATE <b>3/10/69</b>	
"Patient's request for payment on file." 20. DIAGNOSES    EMPLOYMENT RELATED    A. <input type="checkbox"/> YES    B. <input type="checkbox"/> NO (If yes, give name and address of employer)										LEAVE BLANK _____ _____	
21. STATEMENT COVER'S PERIOD FROM: <b>03   10   69</b> TO: <b>03   31   69</b>		22. DATE OF FIRST VISIT		23. DATE OF LAST VISIT		24. PATIENT <input type="checkbox"/> DIS-CHARGED <input checked="" type="checkbox"/> STILL RECEIVES SERVICES <input type="checkbox"/> DIED <input type="checkbox"/> VISITS EXHAUSTED		25. DATE APPLICABLE TO ITEM 19			
26. STATEMENT OF SERVICES RENDERED				27. POST-HOSPITAL PLAN		28. MEDICAL PLAN		29. POST-HOSPITAL PLAN		30. MEDICAL PLAN	
PRIMARY PURPOSE OF VISIT A. Skilled Nursing Care B. Physical Therapy C. Speech Therapy D. Occupational Therapy E. Medical Social Services F. Home Health Aide G. Other Visits (Specify)				NO VISITS    CHARGES \$    \$		NO VISITS    CHARGES \$    \$		A. TOTAL CHARGES <b>\$16.00</b>		A. VERIFIED DEDUCTIBLE <b>\$16.00</b>	
H. Total No. of Units of Service I. Charge per unit of Service \$								B. REIMBURSEMENT RATE <b>1.00</b>		B. VERIFIED COINSURANCE <b>1.00</b>	
J. TOTALS \$    \$								C. REIMBURSEMENT AMT A TIMES B <b>21.00</b>		C. TOTAL CHARGES <b>21.00</b>	
K. Other (Specify) <b>Rental of wheel chair</b>								D. REIMBURSEMENT RATE <b>90%</b>		D. REIMBURSEMENT RATE <b>90%</b>	
L. TOTAL CHARGES \$    \$								E. C TIMES D <b>18.90</b>		E. C TIMES D <b>18.90</b>	
M. AMOUNT PAID BY PATIENT \$    \$								F. E LESS A <b>2.90</b>		F. E LESS A <b>2.90</b>	
I certify that required physician's certification and recertifications are on file.								G. REIMBURSEMENT AMT 80 % OF F <b>2.32</b>		G. REIMBURSEMENT AMT 80 % OF F <b>2.32</b>	
SIGNATURE OF HOME HEALTH AGENCY REPRESENTATIVE <b>/s/ Henry Daly</b>						DATE FORWARDED <b>04   10   69</b>		APPROVED BY <b>/s/ Thomas Sims</b>		DATE APPROVED <b>04   12   69</b>	
FORM SSA-1487 (4-66)    HOME HEALTH AGENCY COPY											











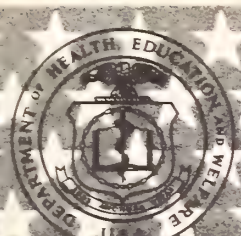






check HD 7102 W4 A3 no. 11-5

D-101



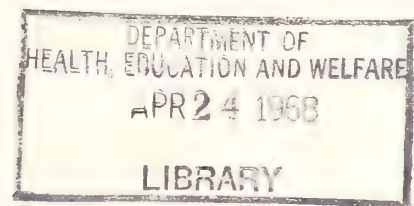
# HOME HEALTH AGENCY MANUAL REVISION

U.S. DEPARTMENT OF  
HEALTH, EDUCATION, AND WELFARE  
SOCIAL SECURITY ADMINISTRATION  
HIM-11

HEALTH INSURANCE FOR THE AGED

ARCH 1968

NO. 5



## New Material

## Replacement Pages

## Discard Pages

Sec. 400-405  
Example XI-Sec. 460

41-42 (4 pp.)  
59-65 (7 pp.)

41-42 (2 pp.)  
59-60 (2 pp.)

Section 401, General Billing Information, has been expanded to indicate that form SSA-1483, Provider Billing For Medical and Other Health Services, will be submitted for Part B services which do not qualify for payment as home health services.

Section 460, Completing Items on Form SSA-1483, is new and should be reviewed in its entirety.

Example XI, Final Billing - Part A - Physician Terminates Plan - Equipment Still Needed, has been changed to show that the patient was discharged and that the discharge date is shown on the billing form.

Example XII, Billing for Rental of Equipment - Part B, illustrates a completed form SSA-1483 showing the rental of an item.

We are distributing one copy of this transmittal directly to each Home Health Agency. Additional copies will be distributed to the intermediaries when they become available.

Thomas M. Tierney, Director  
Bureau of Health Insurance

Action Notes: The last line on page 17a should be changed to read:  
"secutive days in (1) a participating hospital, psych-"

Delete the example at the bottom of page 30; it contains an error which will be corrected in a future transmittal.

§ 405, item 23G, page 45 should be changed so that the next to the last sentence of the example reads:  
"Charges times rate is \$22.50, subtracting \$15 of the deductible (see item 23A) leaves \$7.50; 80 percent of \$7.50 is \$6."

Delete § 420, page 46.

Delete the parenthetical sentence on top of the second column of page 43.

In Table of Contents, Chapter IV,  
Delete reference to Rental of durable medical equipment,  
§ 420.  
Insert reference: Completing items on Form SSA-1483, § 460.



#### 400. INTERVIEWING THE PATIENT ABOUT HIS DEDUCTIBLE STATUS

If it is apparent that the home health services will be charged to supplementary medical insurance rather than to hospital insurance, i.e., there was no prior hospital or extended care facility stay, the plan was not established within 14 days of discharge, benefits were exhausted under a Part A plan, or the home health agency specializes in treating mental diseases, the home health agency will want to discuss the patient's deductible status with him or his representative. (For more detailed information about the deductible, see § 220.1.)

Before the home health agency attempts to collect the \$50 deductible or any portion of it, it should satisfy itself that the deductible has not been met. This should be done by a careful interview with the patient, or a member of his family or other person if he is unable to conduct his own affairs, and by reference to the intermediary's reply to the start of care notice.

The intermediary's reply to the start of care notice will indicate whether the deductible has been met or not met. However, if the reply indicates that the deductible has not been met, there will be no indication of the remaining expenses needed to satisfy the deductible. The patient, in that event, may have a medicare utilization notice or explanation of benefits indicating what part of the deductible he has met. If he has such a notice, the home health agency may collect from the patient the portion of the deductible not met. If the patient has bills for other expenses which could meet the deductible he should submit them promptly to the medical insurance carrier and it will not be necessary for the agency to collect any part of the deductible.

When the intermediary receives the agency's billing, it will query the Social Security Administration central record for the amount of the deductible remaining to be met.

Any overpayments by the patient for the deductible, discovered when the intermediary verifies the status of the deductible with the Social Security Administration, will be refunded to the patient by the intermediary and the agency payment adjusted accordingly.

If the agency collects less than is due, the intermediary will notify it of the amount remaining to be collected on the deductible after processing the bill.

The agency should not bill a third party until the patient's deductible status is known.

#### 401. GENERAL BILLING INFORMATION

Form SSA-1487, Home Health Agency Report and Billing should be submitted for covered home health services furnished a medicare patient under a plan of treatment before visits are exhausted.

Billings should be submitted on a regular basis until the allowable visits are exhausted. An SSA-1487 should be submitted when:

- A. The home health plan of treatment is terminated.
- B. Visits are exhausted.
- C. Visits are switched from Part B to Part A.
- D. Part B visits and **other** home health services have been rendered and the billing for them will not meet the \$50 deductible.
- E. The patient or his representative refuses to request that payment be made on his behalf. In this case, show "Refused Payment" in the open area under item 22. (Your intermediary can furnish instructions on how to bill if the patient subsequently decides to request payment.)

Services provided in different accounting periods should not be put on the same bill. At the end of your accounting period, you should submit a bill which contains all services furnished to the patient since the last bill and through the end of the period. Services furnished in the following accounting period should be on a separate bill.

Form SSA-1483, Provider Billing for Medical and Other Health Services, should be submitted for Part B services which do not qualify for payment as home health services.

Specifically, the home health agency should use an SSA-1483 in the following situations:

1. The patient is not currently entitled to either Part A or Part B benefits, e.g., does not meet prior stay or physician certification requirements, etc., the patient has Part B coverage, and the agency bills for any of the following services:

a. Surgical dressings, splints, casts, and other devices used for reduction of fractures and dislocations,

b. Rental or purchase of durable medical equipment,

c. Ambulance service,

d. Prosthetic devices,

e. Limb, arm, back, and neck braces, trusses and artificial limbs, arms, and eyes.

2. The patient is receiving home health visits under Part A or B, he has Part B coverage and the agency bills for ambulance service (which is not a home health service) to the extent provided in the regulations.

A start of care notice is not necessary before billing on an SSA-1483. Upon receipt of the SSA-1483 the intermediary will send a Part B query to SSA if the Part B deductible is not met.

405. COMPLETION OF HOME HEALTH AGENCY BILLING (FORM SSA-1487)  
Examples of completed billing forms are in § 450.

Items 1 through 14 should be completed on the initial billing in the manner described in § 325 (start of care notice).

Items 4, 5, 9, 14, 15, and 16 may be omitted on second and subsequent billings. Items 11 and 12 may also be omitted on subsequent billings unless there are later inpatient stays in a hospital or extended care facility (see below).

Items 11 and 12. Name and Address of Institution, etc., and Verified Dates, etc.--The information given



on the initial billing on prior inpatient stays should not be repeated on the second or subsequent billings. However, any subsequent inpatient stays in a hospital or extended care facility should be reported in these items on the next billing. The dates of stay should be entered only if verified with the institution. Once a later inpatient stay has been entered on a billing it should not be repeated on a subsequent billing.

This later information on inpatient admission and discharge is needed to determine if a new spell of illness has begun or the 1-year period for visits has been extended. See § 215.1 for the effect of a later stay on entitlement to Part A home health visits.

Entries in these items do not affect other items on the SSA-1487 unless they start a new spell of illness. The original "Date Care Started" (Item 10) and "Date Home Health Plan Established" (Item 13) will remain the same.

**Item 13. Date Home Health Plan Established.**—Never make more than one entry on a billing form in this item. If Part A visits are involved, the entry is the date the initial plan was established in the spell of illness for which you are billing. The fact the initial plan is amended, the patient is reinstitutionalized in the same spell of illness, Part A visits have been exhausted and Part B visits will begin, care extends from one year into another, etc., is immaterial. This same date could, therefore, be shown on subsequent bills for a number of years. However, a new date plan established is shown if the patient becomes eligible for a new series of Part A visits, regardless of whether he was previously receiving visits under Part A or Part B.

**Item 15. Patient's Certification and Payment Request.**—Have the patient or his authorized representative read the statement on the form or on the agency's record if it uses the alternate signature procedure (see below). If the signature is obtained on Form SSA-1487, it is sufficient if it is legible only on the original.

If the patient cannot sign his name because of his physical or mental condition, another person may sign on his behalf, e.g., John J. Jones by Jack A. Smith. (Obtain a brief statement that shows both why the patient himself did not sign the form and the relationship of the signer to the patient. Retain the explanation in the agency's file if the signature is obtained on the agency's own record. If the signature is on Form SSA-1487, the explanation should accompany or be included in the billing form. In certain situations, a home health agency representative may sign on behalf of the patient. (See § 235.1 for who may sign a request for payment.))

The statement should be read to a patient who signs by mark. A signature by mark should be witnessed by a person who knows the patient.

**Signature on Agency Record.**—The agency may arrange with its intermediary to have the patient's signature on its records serve as the request for payment.

The agency should then incorporate the language now on the SSA-1487 by printing or stamping it on either the agency's own start of care form or on a separate form attached to or associated with that form. The following format is suggested:

**"Statement To Permit Payment for Home Health Services or Hospital Insurance and Medical Insurance Benefits to Home Health Agency**

"I certify that the information given by me in applying for payment under Title XVIII of the Social Security Act is correct. I authorize release of all records required to act on this request. I request that payment of authorized benefits be made on my behalf."

The original copy of the first billing form submitted by the agency for services to a patient should be stamped or typed on the patient's signature line to indicate that the patient's statement is on file. The following wording is suggested: "Patient's request for payment on file."

When the intermediary and agency have arranged to put this procedure into effect, the intermediary will thereafter make payment without the patient's signature on the billing form, as long as home health services are being received from the same agency under the same plan of treatment.

**Item 16. Diagnoses.**—Complete on the initial bill. Home health visits under Part A must be related to a condition for which the patient was receiving inpatient hospital or extended care treatment (see § 240.1). Enter all diagnoses as furnished by the attending physician. List the primary diagnosis first with "Primary" in parentheses.

Show the diagnosis in accordance with recognized nomenclature, e.g., "Current Medical Terminology," or "Standard Nomenclature of Diseases and Operations."

This item need not be completed on subsequent bills, but if other diagnoses are identified between the initial and final bills, note such changes or additional diagnoses on the final bill.

Enter an "X" in the appropriate check box to indicate whether or not the condition is employment re-

# Example XI

## XI. FINAL BILLING—PART A—PHYSICIAN TERMINATES PLAN—EQUIPMENT STILL NEEDED

On March 9, 1969, the patient's physician decides that visits are no longer necessary. However, the wheelchair will still be required.

The home health agency will rent the patient the wheelchair after March 9, 1969.

This example shows the last Part A billing form for services to March 9, 1969.

DEPARTMENT OF HEALTH, EDUCATION, AND WELFARE SOCIAL SECURITY ADMINISTRATION										HOME HEALTH AGENCY REPORT AND BILLING HOSPITAL AND MEDICAL INSURANCE BENEFITS—SOCIAL SECURITY ACT										Form Approved, Budget Bureau No. No. 72-R738																																																																																											
1. PATIENT'S LAST NAME <b>Doe</b>					2. HEALTH INSURANCE CLAIM NUMBER <b>000-00-0000 A</b>					3. PATIENT'S ADDRESS (Street number, City, State, Zip Code) <b>6401 Security Blvd., Baltimore, Md. 21235</b>					4. DATE OF BIRTH ____/____/____					5. SEX <input type="checkbox"/> M <input type="checkbox"/> F																																																																																											
6. HOME HEALTH AGENCY NAME AND ADDRESS <b>Neighborhood Nurse Association 425 East 165th, West Baltimore, Md. 21207</b>										7. PROVIDER NO. <b>000 000</b>					9. NAME AND ADDRESS OF ATTENDING PHYSICIAN																																																																																																
8. MEDICAL RECORD NO.										10. DATE CARE STARTED <b>07/21/68</b>										11. NAME AND ADDRESS OF INSTITUTION, IF ANY, CARING FOR CONDITION LATER REQUIRING HOME HEALTH SERVICES																																																																																											
12. VERIFIED DATES OF STAY IN ITEM 11 FROM ____ TO ____										13. DATE HOME HEALTH PLAN ESTABLISHED <b>07/20/68</b>																																																																																																					
14. PAYMENT SOURCE FOR CHARGES TO PATIENT A. <input type="checkbox"/> SELF OR FAMILY C. <input type="checkbox"/> BLUE CROSS E. <input type="checkbox"/> PUBLIC AGENCY (Give name) B. <input type="checkbox"/> PRIVATE INSURANCE D. <input type="checkbox"/> EMPLOYER OR UNION F. <input type="checkbox"/> OTHER (Explain)																																																																																																															
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SIGNATURE (Patient or authorized representative) (Signature by mark must be witnessed)															DATE																																																																																																
16. DIAGNOSES EMPLOYMENT RELATED A. <input type="checkbox"/> YES B. <input type="checkbox"/> NO (If yes, give name and address of employer.)															LEAVE BLANK																																																																																																
17. STATEMENT COVERS PERIOD FROM <b>03/01/69</b> TO <b>03/09/69</b>					18. DATE OF FIRST VISIT ____/____/____					19. DATE OF LAST VISIT ____/____/____					20. DATE APPLICABLE TO ITEM 19 <b>03/09/69</b>																																																																																																
21. STATEMENT OF SERVICES RENDERED										22. POST-HOSPITAL PLAN					23. MEDICAL PLAN																																																																																																
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FORM SSA-1487 (4-66) HOME HEALTH AGENCY COPY																																																																																																															

## EXAMPLE XII

## XII. BILLING FOR RENTAL OF EQUIPMENT - PART B

On March 10, 1969, the rental of the wheelchair takes effect. The rental of durable medical equipment is reimbursable on a cost basis under Part B. This example shows the billing form for the period March 10, 1969, through March 31, 1969.

The agency prepares an SSA-1483 since the patient is no longer under a plan of treatment.

The agency does not complete items 24 or 25.

On receipt of the bill the intermediary queries to SSA central records for the patient's 1969 deductible status. The reply indicates that \$16 of the deductible remains to be met.

The patient owes \$16 toward the Part B deductible. \$16 is subtracted from the total charges of \$21 leaving a total of \$5. Twenty percent of \$5 is \$1 which the patient owes as coinsurance. \$16 is entered in Item 24 B and \$1 in 24 C.

The \$21 total charges are multiplied by the 90% reimbursement rate leaving a total of \$18.90. The \$16 deductible is subtracted leaving a total of \$2.90. Eighty percent of this amount or \$2.32 is entered in Item 25 in the "Provider" block. 0 is entered in "Patient" block.



**PROVIDER BILLING FOR MEDICAL AND OTHER HEALTH SERVICES**  
**MEDICAL INSURANCE BENEFITS - SOCIAL SECURITY ACT**

Form Approved  
 Budget Bureau  
 No. 72-R0738

1. Patient's last name Doe	First name John	MI H	2. Health insurance claim number 000-00-0000A
3. Patient's address (Street number, City, State, ZIP Code) 6401 Security Blvd., Baltimore, Md. 21235			4. Date of birth 09   09   99
5. Sex <input checked="" type="checkbox"/> M <input type="checkbox"/> F			
6. Provider name and address, (City and State) Visiting Nurse Association Baltimore, Md. 21201		7. Provider number 000000	9. Type of service A. <input type="checkbox"/> Inpatient C. <input checked="" type="checkbox"/> Other (Specify) Home Health Agency B. <input type="checkbox"/> Outpatient
		8. Medical record number	

If you have other health insurance or if your State Medical Assistance Agency will pay part of your medical expenses and you want information about this claim released to them upon their request complete items 10 and 11.

10. Insuring organization or State agency name and address	11. Policy or medical assistance number
12. Patient's Certification, Authorization to Release Information, and Payment Request. I certify that the information given by me in applying for payment under Title XVIII of the Social Security Act is correct. I authorize any holder of medical or other information about me to release to the Social Security Administration or its intermediaries or carriers any information needed for this or a related medicare claim. I request that payment of authorized benefits be made on my behalf.	

<input checked="" type="checkbox"/> Contained in provider's record	Signature (Patient or authorized representative) (Signature by mark must be witnessed)	Date
13. Nature of illness or injury  Cerebral Vascular Accident		<input type="checkbox"/> Check here if illness or injury was connected with employment Do not use this space
14. Surgical procedures		

15. Statement of services	Covered Charges	16. Statement Covers Period	First service	Last service
A. Clinic visit ( )			03   10   69	03   31   69
B. Emergency room ( )		17. Blood Information	A. Pints furnished	B. Pints replaced
C. Laboratory			C. Pints	D. Charge per pint
D. Radiology		18. Professional component (hospital inpatients)	E. Patient paid for deductible	
E. Pharmacy		A. Pathology	B. Radiology	
F. Blood		20. Date benefits exhausted or HH plan terminated	19. Other professional component	
G. Ambulance		03   09   69	21. Patient paid (Excluding IFE)	
H. Physical therapy		22. I certify that the required physician's certification is on file.	None	
I. Other (Specify)		S. I. Sides	23. Date forwarded	
Rental of Wheel Chair	21 00	FOR INTERMEDIARY USE ONLY		
		24. Verified Patient Liability		
		A. Blood deductible	B. Cash deductible	C. Coinsurance
			\$16.00	\$1.00
J. TOTAL	21 00	25. Payment Distribution	26. Date approved	
		Provider	Patient	
		\$2.32	0	04   19   69

Remarks:  
 \*Summit Rental Agency  
 25 Paca St.  
 Baltimore, Md. 21202





Items 10 and 11. Complementary Coverage Information.--If information about the claim is to be sent to a complementary insurer at the patient's request, and the agency does not object, the name and address of the organization or agency should be shown. The identifying number will be shown in item 11.

Item 12. Patient's Certification.--Have the patient or his authorized representative read the statement on the form or on the agency's record if it uses the alternate signature procedure. (See §§ 405ff.)

If the agency obtains the signature on its own form, check the block marked "Contained in provider's record." If the signature is obtained on form SSA-1483, it is sufficient if it is legible on the original only. A signature is required with each billing. If the agency obtains a signature on its own record, it will remain effective as long as the particular service is being received from the same agency according to the physician's order.

If the patient cannot sign his name because of his physical or mental condition, another person may sign on his behalf, e.g., John J. Jones by Jack A. Smith. In certain situations, a home health agency representative may sign on behalf of the patient. (See § 235.1 for who may file a payment request.) Briefly explain why the patient did not sign the form himself and show the relationship of the signer to the patient. This explanation should be retained in the agency's file if the signature is obtained on the home health agency's own record. If the signature is on form SSA-1483, the explanation should accompany or be included on the billing form. The statement should be read to the patient who signs by mark.

A signature by mark should be witnessed by a person who knows the patient. Enter the name and address of any person witnessing a signature by mark.

If it is impractical to obtain the patient's signature because the agency does not make a visit to his home (e.g., the physician certifies that the patient needs a certain item of durable medical equipment but no visits are certified), the agency may furnish the equipment and need not obtain the patient's signature. An agency representative should sign on behalf of the patient and write in this item "Patient not visited."

Item 13. Nature of Illness or Injury.--An entry must be made only on bills where the patient's health insurance number ends in "0"- "4" - "5" or "8."



When necessary, enter the nature of illness or injury as furnished by the attending physician. Acceptable medical terminology should be used, such as "Current Medical Terminology", "Standard Nomenclature of Diseases and Operations," and "International Classification of Diseases Adapted."

If the condition was employment related, check the block and show the name and address of the employer, if known. Where the agency knows that a workmen's compensation claim has been made, it should insert or attach a statement identifying the carrier, if any, handling the workmen's compensation claim, and give any available details about the claim. (See §§ 250ff for additional information.)

Item 14. Surgical Procedures--No entry should be made in this item.

Item 15. Statement of Services Rendered--Enter the covered Part B charges during the billing period which do not constitute reimbursable home health services. If the service was furnished under arrangements with suppliers outside the agency, but is being billed by the agency, enter an asterisk by the type of service furnished and cross-refer this to the name and address of the supplier in remarks.

H. Physical therapy		
I. Other (Specify)	15	00*
J. TOTAL	15	00

Remarks:

\* Doran's Rental Shop  
2401 Birge  
Baltimore, Md. 21000

Home Health Agencies should make no entry in A. Clinic Visit, B. Emergency Room, C. Laboratory, D. Radiology, E. Pharmacy, F. Blood.

Durable medical equipment furnished should be entered under "I." Indicate whether it is rented or purchased. Show the full purchase price if the equipment is purchased.

Show total covered charges on line J.

Item 16. Statement Covers Period.--Enter the dates of the first and last service furnished during the billing period. Do not bill for an inclusive period spanning two calendar years, since the deductible applies to the charges incurred in each year independently. Usually the date of the first service should be later than the date of the last service on the preceding bill.

Item 17. Blood Information.--Home Health Agencies should make no entry in item 17.

Item 18. Professional Component (Hospital Inpatients).--Home Health Agencies should make no entry in this item.

Item 19. Other Professional Component.--Home Health Agencies should make no entry in this item.

Item 20. Date Benefits Exhausted or Home Health Plan Terminated.--Enter a date only when home health visits are exhausted or the physician's plan of treatment is terminated.

Item 21. Patient Paid.--Enter the amount, if any, paid by the patient. Do not include any amount paid by a separate billing for physicians' services.

Item 22. Signature of Agency Representative.--Before the billing is forwarded to the intermediary, an agency representative should assure himself that the physician's certification as to medical necessity is on file. The representative should sign his name; a stamped signature is acceptable.

Item 23. Date Forwarded.--Enter the date on which the form was forwarded to the intermediary.

The balance of the form is for the use of the intermediary in computing the payments to be made to the agency and/or patient.

The Home Health Agency should make no entry in items 24, 25, and 26.









Order HD710224A3 Vol. 206

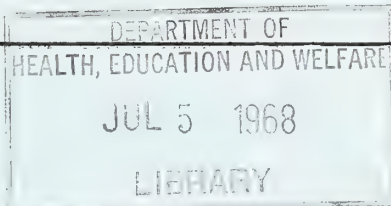
# HOME HEALTH AGENCY MANUAL REVISION

U.S. DEPARTMENT OF  
HEALTH, EDUCATION, AND WELFARE  
SOCIAL SECURITY ADMINISTRATION  
HIM-11

HEALTH INSURANCE FOR THE AGED

APRIL 1968

NO. 6



## New Material

## Pages

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Sec. H115-H122.3(Cont.)	5
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Sec. H210.2-H221(Cont.)	2
Sec. H232.7-H233.1	3

This transmittal furnishes home health agencies with additional instructions on the 1967 Amendments to the Social Security Act.

The material is in the form of supplements to Chapters I and II, and should be inserted at the end of the chapter to which it relates. To facilitate identification, supplements are printed on colored paper. For ease of reference, amendment supplement sections show an "H" prefix and, where practical, the related permanent manual section number has been used. As soon as possible, we will integrate the supplement material in the permanent manual text.

A limited direct distribution of 2 copies of this supplement is being made to each agency. Intermediaries will complete distribution when additional copies are available.

Thomas M. Tierney, Director  
Bureau of Health Insurance





CHAPTER I  
1967 AMENDMENTS SUPPLEMENT

GENERAL INFORMATION ABOUT THE PROGRAM

Section

Podiatrists' Services

Podiatrists as Physicians..... H115.1

Hospital Insurance Benefits Entitlement

Transitional Provision..... H120B

Supplementary Medical Insurance Benefits

Enrollment..... H122A  
    Premiums..... H122.1  
    Beginning of Coverage..... H122.2  
    Coverage Ends..... H122.3





### Podiatrists' Services

**H115.1 Podiatrists as Physicians.**--Effective January 1, 1968, coverage of physicians' services is extended to include services performed by podiatrists. The intent of the amendments is to allow payment for certain foot care services whether furnished by a doctor or medicine, osteopathy, or podiatry (to the extent that each is legally authorized to perform the services). Certain foot care services (including routine care), however, are excluded regardless of who performs them. (See § H233.)

**A. Scope of Coverage of Podiatrists' Services.**--Podiatrists (chiropractors) are included within the definition of "physician" (except as indicated in B. below) but only with respect to those functions which they are legally authorized to perform in the State in which they perform them. This means that the professional services provided by a podiatrist within the scope of his applicable State license (except those services which are specifically excluded) are "physicians' services," reimbursable on a reasonable charge basis under Part B.

Podiatrists may hold any of the following professional degrees, of which the first three are the most common: Pod.D or D.P. (Doctor of Podiatry), D.S.C. (Doctor of Surgical Chiropody), D.P.M. (Doctor of Podiatric Medicine), D.S.P. (Doctor of Surgical Podiatry), Graduate in Podiatry, Master Chiropractor, or in a very few instances another podiatry degree. Within a particular State, all individuals holding any of these degrees are licensed to perform the same functions; however, there are variations from State to State as to the authorized scope of podiatric practice.

**B. Services for Which Podiatrists Are Excluded From the Definition of Physician.**--

**1. Physician Certification and Recertification of the Need for Provider Services (§ 240).**--A podiatrist is not a "physician" for the purpose of making the required physician certifications and recertifications of the medical necessity for Part A and Part B provider services. This means that a medical doctor (or osteopath) must complete the certification of necessity for provider services where such certifications are required. However, no certification by a medical doctor is required with respect to a podiatrist's professional services to his patients.

2. Home Health Services Requirements (ss 200ff and 205).---A podiatrist is not a "physician" for the purpose of any of the physician activities required to qualify an organization as a home health agency or required for coverage of home health services. Thus, a podiatrist may not be a "physician" member of the group of professional personnel responsible for establishing policies governing the services provided by the home health agency, nor may a podiatrist furnish any of the "physician" supervision of the agency's services required by the statute or the Conditions of Participation for Home Health Agencies. In addition, a podiatrist is not a "physician" for the purpose of establishing or reviewing the plan of home health treatment required for each patient receiving covered services nor for the purpose of satisfying the requirement that each home health patient must be under the care of a "physician."

### Hospital Insurance Benefits Entitlement

HI20 B. Transitional Provision.--The 1967 amendments modify the quarters of coverage requirement of the transitional provision. The person attaining age 65 after 1967, who is not entitled to monthly benefits under social security or railroad retirement, will need three less quarters of coverage than under the pre-amendment provision. A person attaining age 65 in 1968 needs 3 quarters of coverage; in 1969, 6 quarters of coverage; in 1970, 9 quarters of coverage; etc.

### Supplementary Medical Insurance Benefits

HI22 A. Enrollment.--The 1967 amendments provide that States will be given the option of "buying-in" for all their aged who are eligible for medical assistance under Title XIX, whether or not they are receiving cash assistance.

B3 General Enrollment Period.--The first general enrollment period was to occur October 1, 1967, through December 31, 1967. By special Congressional action, however, this period was extended through March 31, 1968. The 1967 amendments provide that effective January 1, 1969, the general enrollment period will be annual rather than biennial and will run from January 1 through March 31 rather than October 1 through December 31. Coverage will begin on the following July 1.

B4 States.--The 1967 amendments extended from December 31, 1967, to December 31, 1969, the deadline by which States may request an agreement with the Secretary to enroll eligible individuals under the "buy-in" provision. States are also permitted to cover under the agreement persons who attain age 65 and otherwise become eligible after the December 31, 1969, deadline.

HI22.1 Premiums.--Through March 1968, the individual supplementary medical insurance premium was \$3. The law permitted the Secretary of Health, Education, and Welfare to adjust the premium amount consistent with changes in costs of the program, and in December 1967, the Secretary announced a new premium rate of \$4 effective April 1968 through June 1969.

With the 1967 amendments, the law specifies that the Secretary will determine and make known during December of each year the premium rate which will be applicable for a 12-month period to begin the following July 1. When the Secretary makes known a rate change for



Part B, he will issue a public statement setting forth the actuarial assumptions and other bases upon which he arrived at the new rate.

#### HL22.2 Beginning of Coverage

D. Enrollment by a State of its welfare recipients under the 1967 amendments--coverage begins on the latest of the following:

1. July 1, 1966.(no change)
2. First day of the third month after the month the modification or agreement is entered into. (no change)
3. First day of the first month in which the individual is eligible and a member of the group except that (for a State which buys in for medically indigent persons) if the individual is not in such month receiving money payments under titles I, IV(Part A), X, XIV, or XVI, his coverage will begin on the first day of the second month after such month, or on the first day of the first month in which he receives a money payment under one of the above titles, whichever occurs first. (1967 amendments)
4. The date specified in the agreement.

HL22.3A Coverage Ends.--Prior to the 1967 amendments, an individual could request termination of medical insurance by notifying the Social Security Administration in writing during a general enrollment period and coverage would terminate at the close of the general enrollment period. Because of the extension of the 1967 general enrollment period to April 1, 1968, coverage might end on either December 31, 1967, or March 31, 1968, the effective termination date being determined by the period during which the termination request was filed.

The 1967 amendments provide that beginning April 1, 1968, an individual wishing to disenroll ~~may~~ do so at any time, but such disenrollment will not take effect until the close of the calendar quarter following the calendar quarter in which the notice of disenrollment is filed.

C. If an individual is enrolled under a Federal-State agreement, his coverage under the agreement ends on whichever of the following occurs first:

1. The end of the month in which he becomes ineligible (as determined by the State) for welfare money payments or (if the agreement covers all individuals eligible for medical assistance under title XIX), for both money payments and medical assistance. (1967 amendments.)

2. The end of the month before the first month for which he becomes entitled to monthly social security or railroad retirement benefits (if the State's agreement covers only money recipients who are not entitled to such benefits).

3. The end of the month in which the State agreement is terminated.

4. The end of the month in which the individual dies.





CHAPTER II  
1967 AMENDMENTS SUPPLEMENT

COVERAGE OF HOME HEALTH SERVICES

Section

Three-Day Prior Hospitalization

Three-Day Prior Hospitalization Requirement for Coverage  
of Home Health Services Under Part A..... H210.2

Physical Therapy Services Furnished to Outpatients  
Covered Under Medical Insurance

Outpatient Physical Therapy Services..... H221

Exclusion of Refractive Services

Exclusion of Eye Care Services..... H232.7

Exclusion of Foot Care

Excluded Foot Care Services..... H233  
Application of Foot Care Exclusions to  
Provider Services..... H233.1



Three-Day Prior Hospitalization

H210.2 Three-Day Prior Hospitalization Requirement for Coverage of Home Health Services Under Part A.--Effective with hospital discharges occurring on and after January 1, 1968, a new definition of "hospital" applies in determining whether a beneficiary has met the 3-day hospital-stay requirement.

The hospital must:

- A. Provide 24-hour nursing service rendered or supervised by a registered professional nurse and have a licensed practical nurse or registered professional nurse on duty at all times (§ 112.1.E); and
- B. Where licensing of hospitals is provided for under State or local law, be licensed or approved by the State or local licensing agency as meeting the standards established for such licensing (§ 112.1.G); and
- C. Be primarily engaged in providing to inpatients, by or under the supervision of doctors of medicine or osteopathy:
  - 1. diagnostic and therapeutic services for medical diagnosis, treatment and care of injured, disabled, or sick persons, (§ 112.1.A.1), or
  - 2. rehabilitation services for the rehabilitation of injured, disabled, or sick persons (§ 112.1.A.2);and
- D. Not be primarily engaged in providing to inpatients skilled nursing care and related services for patients who require medical or nursing care. (See definition of an extended care facility in § 112.2.)

Psychiatric and tuberculosis hospitals that meet the above hospital requirements also satisfy the prior-stay hospital definition.

Federal hospitals need not be licensed under State or local licensing laws to meet the definition.



Physical Therapy Services Furnished to Outpatients  
Covered Under Medical Insurance

H221. OUTPATIENT PHYSICAL THERAPY SERVICES

Effective July 1, 1968, coverage under Part B of physical therapy furnished on an outpatient basis is expanded by including such services furnished by or under arrangements made by a participating provider of services. Reimbursement for these outpatient physical therapy services will be made to the provider on a cost basis. The patient will be responsible only for the regular Part B deductible and coinsurance amounts (i.e., the annual \$50 deductible and 20 percent coinsurance).

For the purposes of this coverage, the term "provider of services" is extended to include approved clinics, rehabilitation agencies and public health agencies as well as participating hospitals, extended care facilities and home health agencies. To qualify as providers of services; clinics, rehabilitation agencies and public health agencies will be required to meet certain conditions enumerated in the law and to enter into an agreement with the Secretary in which they agree not to charge any beneficiary for covered services for which the program will pay and to refund any erroneous charges made.

Payment would be made for outpatient physical therapy services only where a physician has certified that (1) such services are or were required because the individual needed physical therapy services on an outpatient basis, (2) a plan for furnishing such services has been established and is periodically reviewed by the physician, and (3) such services are or were furnished while the individual is or was under the care of a physician. In addition, the plan of treatment established by the physician must prescribe the type, amount, and duration of the physical therapy services to be furnished the individual.

This new provision represents an extension of coverage in that under present law individuals who are not homebound and therefore are ineligible for home health benefits can secure outpatient physical therapy services only if provided as an incident to a physician's services (i.e., provided under his personal supervision with the charges for such services included in the physician's bill) or as a hospital service furnished incident to a physician's services. Beginning with July 1, 1968, such individuals may secure such services from any provider of services without the requirement that the services be furnished incident to a physician's services. This new provision will also permit a home health patient who runs out of visits to continue to receive covered physical therapy services from the home health agency (or other provider) providing he has Part B coverage.

Exclusion of Refractive Services

H232.7 Exclusion of Eye Care Services.--Effective January 1, 1968, the amendments expand the eye care exclusion in the present law by also excluding from coverage procedures performed to determine the refractive state of the eyes during the course of any eye examination. Thus, expenses for all eye refraction procedures, whether performed by an opthamologist (or any other physician) or by an optometrist and without regard to the reason for the performance of the refraction, are excluded from coverage under the program.

Exclusion of Foot Care

**H233. EXCLUDED FOOT CARE SERVICES**

The amendments limit the scope of covered foot care services by excluding the following types of services under both Part A and Part B, effective January 1, 1968.

**A. Treatment of Flat Foot Conditions and Prescription of Supportive Devices Therefor.**--For the purposes of this exclusion, treatment of "flat foot conditions" means treatment of the local condition of flattened arches regardless of the underlying pathology causing it, except where such treatment is purely incidental to and an integral part of covered foot treatment (for example, treatment of a fracture). The term "treatment" encompasses all phases of services in connection with flat feet, including evaluations as well as any measures or devices designed either to correct the condition or to palliate pain and other symptoms associated with the condition.

**B. Treatment of Subluxations of the Foot.**--For the purposes of this exclusion, the term "subluxation" refers to structural misalignments of the feet (except fractures and complete dislocations) which do not require treatment by surgical methods, regardless of the underlying pathology. Excluded "treatment" of the above conditions includes evaluations as well as the nonsurgical measures, supplies, or appliances used to correct the condition or alleviate symptoms. The exclusion does not apply where such treatment is purely incidental to and an integral part of covered foot treatment (such as treatment of a fracture) or where performed as a part of postoperative care during the period of convalescence from covered foot surgery.

This exclusion does not apply to the ankle joint (talo-crural joint).

**C. Routine Foot Care.**--Routine foot care includes the cutting or removal of corns, warts, or calluses, the trimming of nails, and routine hygienic care. "Routine hygienic care" includes hygienic and preventive maintenance care of the feet, of the type which is ordinarily considered self-care, such as observation and cleansing of the feet, use of skin creams to maintain skin tone of both ambulatory and bedfast patients, nail care not involving surgery, prevention and reduction of corns, calluses and warts, and any services performed in the absence of localized illness, injury, or symptoms involving the foot.



The above types of "routine" care are excluded regardless of the reason for such care. Thus, the fact that a particular individual is unable to perform certain care for himself (for example, because of a physical disability or a predisposing systemic disease such as diabetes or peripheral vascular disease which makes preventive hygienic foot care particularly important) does not change the character of the services and make them "nonroutine." Hygienic and other care which is simply incident to and an integral part of active covered treatment of foot lesions, such as infections and diabetic ulcers, is not considered as "routine" care and hence is not excluded.

**H233.1 Application of Foot Care Exclusions to Provider Services.--**

Charges for provider services furnished in connection with non-covered foot care which are normally separately identified by the provider must be shown as noncovered charges. However, the provider need not identify services in connection with noncovered foot care where it is neither the normal practice to separately identify the services nor administratively feasible to establish a separate charge for such services, or where such services are performed only incidentally at the same time as and as a necessary integral part of a primary covered procedure.



3000 - Definitions

3100 - Services

3200 - Amounts

3300 - Requirements for Payments





Ref. HD 7102 W4A3

no. 11-7



# HOME HEALTH AGENCY MANUAL REVISION

**HEALTH INSURANCE FOR THE AGED**

U.S. DEPARTMENT OF  
HEALTH, EDUCATION, AND WELFARE  
SOCIAL SECURITY ADMINISTRATION  
HIM-11

MAY 1968

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## New Material

## Replacement Pages

D-101

## Discard Pages

Sec. 205.1(Cont.)-210.1(Cont.)      15-17 (9 pp.)      15-17a (4 pp.)

This transmittal furnishes expanded definitions of part-time or intermittent services (§ 205.1C), home health aide services (§ 205.4), and homebound (§ 208.4).

A limited direct distribution of two copies of this revision is being made to each home health agency. Intermediaries will complete distribution when additional copies are available.

Thomas M. Tierney, Director  
Bureau of Health Insurance

**Action Notes:** Delete the first 8 lines (i.e., the material in brackets) at the top of p. 17b.

Delete § H210.2. That material has now been included in § 210.2.

Section 405, item 21, p. 43, par. 3. Delete "homemaker services" in the second sentence and substitute "services of a domestic or housekeeping services unrelated to patient care."





the supervisor accompanies the student on a visit.)

**C. Part-Time or Intermittent Services.**--Part-time or intermittent service of professional personnel and home health aides is usually service for a few hours a day several times a week. Occasionally, more service, i.e., 8 hours, may be provided for a limited period when the physician recommends and, when because of unusual circumstances, neither the alternative of part-time care nor institutionalization is feasible.

Services of **professional staff** usually are provided less frequently and for shorter periods of time than are the services of home health aides. For physical, speech, and occupational therapists and medical social workers, visits ordinarily should not exceed 1 hour.

**Home health aide visits** usually will be provided two or three times a week for several hours. Thus most agencies average 20 hours or less a week for the Medicare case load. This average reflects the planning and flexibility needed to provide up to 8 hours a day, 5 days a week for the few very ill patients who need extensive care and have no family member present during the day.

In recognition of the span of normal practice followed in home care, reimbursement may ordinarily be made for up to 100 hours a month of home health aide service assuming no question exists regarding the coverage status of such services. By the same token, on an intermittent basis, service for up to 8 hours a day, 5 days a week may be provided when medically necessary due to unusual circumstances, e.g., the patient has just returned from the hospital and must be oriented, along with his family, to various aspects of home care; the patient's condition is terminal; or he has suffered a relapse which while requiring more intensive care either does not necessitate institutionalization or institutionalization cannot immediately be arranged. The agency will need to explain for patients having service exceeding a rate of 100 hours per month, why this amount of care was required.

**205.2 Physical, Speech, and Occupational Therapy.**--Physical, speech, and occupational therapy furnished by the home health agency is covered when provided in accordance with a physician's orders and by or under the supervision of a qualified therapist.

The cost of the services of aides and other personnel providing supplementary services is covered when such an aide or other person is trained and supervised by appropriate professional personnel.

**205.3 Medical Social Services.**--These services must be under the direction of a physician and must be given by or under the supervision of a qualified medical or psychiatric social worker.

**205.4 Services of a Home Health Aide.**--The primary function of a home health aide is the personal care of a patient. The services of a home health aide are given under the supervision of a registered professional nurse, and if appropriate, a physical, speech, or occupational therapist. The assignment of a home health aide to a particular case must be made in accordance with a written plan of treatment established by a physician which indicates the patient's need for personal care services. The specific personal care services to be provided by the home health aide must be determined by a registered professional nurse and not by the home health aide.

Personal care duties which may be performed by a home health aide include assistance in the activities of daily living, e.g., helping the patient to bathe, to get in and out of bed, to care for his hair and teeth, to exercise, and to take medications specifically ordered by a physician which are ordinarily self-administered, and retraining the patient in necessary self-help skills.

While the primary need of the patient for home health aide services furnished in the course of a particular visit may be for personal care services furnished by the aide, the home health aide may also perform certain household services which are designated to the home health aide in order to prevent or postpone the patient's institutionalization. These services may include keeping a safe environment in areas of the home used by the patient, e.g., changing the bed, light cleaning, rearrangements to assure that the beneficiary can safely reach necessary supplies or medication, laundering essential to the comfort and cleanliness of the patient, etc., seeing to it that the nutritional needs (which may include the purchase of food and assistance in the preparation of meals) of the patient are met, and washing utensils used in the course of the visit. If these household services are incidental and do not substantially increase the time spent by the home health aide, the cost of the entire visit would be reimbursable. Housekeeping services which would materially increase the amount of time required to be spent by the home health aide to make the visit above the amount of time necessitated by care for the patient are not reimbursable. Where another member of the household is an equally aged and feeble or ill person, e.g., an aged spouse or parent of the beneficiary, certain services performed by the home health aide may be advantageous to both members



of the household but would nevertheless be reimbursable if the amount of time spent by the aide is not materially increased in order to serve the nonbeneficiary member.

The discussion of part-time or intermittent services in § 205.1C is also applicable to home health aides.

**205.5 Medical Supplies (Except for Drugs and Biologicals) and the Use of Medical Appliances.**--Medical supplies are items which are essential to enable the home health agency to carry out effectively in the home the kinds of care which the physician has ordered. Medical supplies include (but are not limited to) gauze, cotton, adhesive bandage, surgical dressings, catheters, surgical gloves, rubbing alcohol, irrigating solutions, intravenous fluids, and oxygen.

Medical appliances are items owned or rented by the home health agency and loaned to the patient to facilitate his treatment and rehabilitation. They include, but are not limited to, such items as bedpans, wheelchairs, crutches, hospital beds, trapeze bars, oxygen tents, intermittent positive pressure machines, and air pressure mattresses.

Drugs and biologicals are excluded from coverage as items or services administered by home health agencies, under either hospital insurance or medical insurance. They may, in certain cases, be covered under medical insurance when administered by a physician as a part of his professional services and are not capable of being self-administered.

**205.6 Services of Interns and Residents.**--Home health services include the medical services of interns and residents-in-training under an approved hospital teaching program (if the agency has an affiliation with or is under common control of a hospital providing such medical services). "Approved" means approved by the Council on Medical Education of the American Medical Association, or in the case of an osteopathic hospital, the Committee on Hospitals of the Bureau of Professional Education of the American Osteopathic Association, and, in the case of an intern or resident-in-training in the field of dentistry, approved by the Council on Dental Education of the American Dental Association. Reimbursement is provided under Part B for the services other hospital interns and residents furnish to beneficiaries receiving home health services.

**205.7 Outpatient Services.**--Outpatient services include any of the items or services described above which are provided under arrangements on an outpatient basis at a hospital, extended care facility, rehabilitation center, or outpatient department affiliated with a medical school, and (1) which require equipment which cannot readily be made available at the patient's place of residence or (2) which



are furnished while he is at the facility to receive the services described in (1). The hospital, extended care facility, or outpatient department affiliated with a medical school must all be qualified providers of services. However, there are special provisions for the use of the facilities of rehabilitation centers (see § 200.3). The cost of transporting an individual to a facility cannot be reimbursed as a home health service.

**208. CONDITIONS FOR COVERAGE FOR HOME HEALTH SERVICES UNDER BOTH HOSPITAL AND MEDICAL INSURANCE**

**208.1 Patient Must be Under Care of a Physician.**--Items and services must be furnished to an individual who is under the care of a physician. This physician may be the patient's private physician; or, a physician on the staff of the home health agency; or, a physician working under an arrangement with the institution which is the patient's residence; or if the agency is hospital-based, a physician on the hospital or agency staff. The attending physician establishes the plan of treatment and also certifies to the necessity for home health services.

**208.2 Services Furnished by Agency.**--Items and services must be furnished by a participating home health agency or by others under arrangements made by the agency. (See § 200.2 for definition of "under arrangements.")

**208.3 Services Furnished Under a Plan.**--Items and services must be furnished under a plan established and periodically reviewed by a physician and which relates the items and services to the patient's condition. A plan must be reduced to writing by the physician and be made available to the home health agency which has accepted the patient as a client. (See § 210.3 for coverage of Part A services rendered before the plan is reduced to writing.) Part B home health services furnished before the plan is reduced to writing are covered if authorized by a physician. However, the plan is to be reduced to writing prior to the submission of the bill. The plan should specify the types of services required and should, as far as possible, provide a long-range forecast of likely changes in the patient's condition. It should include the diagnosis and a description of the patient's functional limitation resulting from the illness or injury, the type and frequency of nursing services needed, drugs and medications, special diets, activities permitted, rehabilitation and therapy services, medical social services, home health aide services, and the medical supplies and appliances necessary.

The plan is signed by the attending physician and incorporated into the agency's permanent record for the patient. Any changes should be

made in writing and signed by the physician or by a registered professional nurse on the staff of the agency pursuant to the physician's oral orders. All changes in orders for dangerous drugs and narcotics must be signed by the physician.

The plan must be reviewed by the attending physician, in consultation with agency professional personnel, at such intervals as the severity of the patient's illness requires but at least every 2 months. Each review of a patient's plan should contain the initials of the physician and show the date performed. The agency's record need not be forwarded to the intermediary for review but will be retained in the agency's file.

When an individual has coverage under both Part A and Part B, home health plans under both parts should not operate concurrently. For example, a plan of treatment is established after hospitalization for a condition for which the patient was hospitalized, and the patient later requires home health services for a condition unrelated to the previous hospitalization but while the original plan of treatment is still in effect. The original plan of treatment should be modified to take into account the required home health services for the condition not related to previous hospitalization. Otherwise, there would be administrative difficulties in counting home health visits, particularly if two home health agencies become involved. Of course, if the patient does not have Part B coverage, the original plan of treatment cannot be modified to provide home health services not related to prior hospitalization.

When benefits under hospital insurance have been exhausted and a change to benefits under medical insurance is made, it is not necessary for the physician to change the plan of treatment.

**208.4 Patient Confined to His Home.**--In order for a beneficiary to be eligible to receive covered home health services under both Part A and Part B, the law requires that a physician certify in all cases that the beneficiary is confined to his home (see § 240.1). An individual does not have to be bedridden to be considered as confined to his home. However, the condition of these patients should be such that there exists a normal inability to leave home and, consequently, leaving their homes would require a considerable and taxing effort. If the patient does in fact leave the home, the patient may nevertheless be considered homebound if the absences from the home are infrequent or for periods of relatively short duration. It is expected that in most instances absences from the home which occur will be for the purpose of receiving medical treatment. However, occasional absences from the home for nonmedical purposes, e.g., an occasional trip to the barber, a walk around the block or a drive, would not



necessitate a finding that the individual is not homebound so long as they are undertaken on an infrequent basis or are of relatively short duration and do not indicate that the patient has the capacity to obtain the health care provided outside rather than in the home.

Generally speaking, a beneficiary will be considered to be homebound if he has a condition due to an illness or injury which restricts his ability to leave his place of residence except with the aid of supportive devices such as crutches, canes, wheelchairs, and walkers, the use of special transportation, or the assistance of another person or if he has a condition which is such that leaving his home is medically contraindicated. Some examples of homebound patients which are also illustrative of the factors to be taken into account in determining whether a homebound condition exists would be: (1) a beneficiary paralyzed from a stroke who is confined to a wheelchair or who requires the aid of crutches in order to walk; (2) a beneficiary who is blind or senile and, therefore, requires the assistance of another person in leaving his place of residence; (3) a beneficiary who has lost the use of his upper extremities and, therefore, is unable to open doors, use handrails on stairways, etc., and, therefore, requires the assistance of another individual in leaving his place of residence; (4) a patient who has just returned from a hospital stay involving surgery who may be suffering from resultant weakness and pain and, therefore, his actions may be restricted by his physician to certain specified and limited activities such as getting out of bed only for a specified period of time, walking stairs only once a day, etc.; and (5) a patient with arteriosclerotic heart disease of such severity that he must avoid all stress and physical activity.

The aged person who does not often travel from his home because of feebleness and insecurity brought on by advanced age would not be considered confined to his home for purposes of receiving home health services unless he meets one of the above conditions. A patient who requires speech therapy but does not require physical therapy or nursing services must also meet one of the above conditions in order to be considered as confined to his home. Thus, a person who has undergone a laryngectomy yet is recovered to the point of being able to get about normally without undue effort would not be considered as confined to his home.

Although a patient must be confined to his home to be eligible for covered home health services, some services cannot be provided at the patient's residence because equipment is required which cannot be made available there. If the services required by an individual involve the use of such equipment, the home health agency may make arrangements with a hospital, extended care facility, or a rehabilitation center to provide these services on an outpatient basis



(see §§ 200.2 and 205.7). However, even in these situations, for the services to be covered as home health services the patient must be considered as confined to his home; and to receive such outpatient services it may be expected that a homebound patient will generally require the use of supportive devices, special transportation, or the assistance of another person to travel to the appropriate facility.

If for any reason a question is raised as to whether an individual is confined to his home, the agency will be requested to furnish the intermediary with the information necessary to establish that the beneficiary is homebound as defined above.

**208.5 Patient's Place of Residence.**--A patient's residence is wherever he makes his home. This may be his own dwelling, an apartment, a relative's home, a home for the aged, or some other type of institution. However, an institution may not be considered a patient's residence if it:

(a) Meets at least the basic requirement in the definition of a hospital (§ 112.1), i.e., it is primarily engaged in providing by or under the supervision of physicians, to inpatients, diagnostic and therapeutic services for medical diagnosis, treatment, and care of injured, disabled, or sick persons, or rehabilitation services for the rehabilitation of injured, disabled, or sick persons, or

(b) Meets at least the basic requirement in the definition of an extended care facility (§ 112.2), i.e., it is primarily engaged in providing to inpatients skilled nursing care and related services for patients who require medical or nursing care, or rehabilitation services for the rehabilitation of injured, disabled, or sick persons. If a patient is transferred from a participating extended care facility to a nonparticipating part of the facility which he uses as his home, the part will not be considered the patient's residence if it meets this requirement.

Thus, if an individual is a patient in an institution or distinct part of an institution which provides the services described in (a) or (b) above, he is not entitled to have payment made for home health services under either Part A or Part B since such an institution may not be considered his residence.

When a patient remains in a participating extended care facility following his discharge from active care, the facility may not be considered his residence for purposes of home health coverage.

## 210. SPECIAL CONDITIONS FOR COVERAGE OF HOME HEALTH SERVICES UNDER HOSPITAL INSURANCE (PART A)

In addition to the conditions listed in § 208, the following conditions must be met for coverage under hospital insurance.

**210.1 Effect of Spell of Illness on Coverage.**--Hospital insurance coverage extends only to home health visits (100 or less) furnished after the beginning of one spell of illness and before the beginning of the next.

The controlling event is the **beginning** of the spell of illness. Thus, the spell of illness requirement is satisfied if, when the home health services are furnished, the patient is either in a spell of illness, or has ended a spell of illness and not begun a new one. A series of visits ends with the beginning of a new spell of illness. (See § 112.3 for the definition of spell of illness and the examples in § 210.2 for the interrelationship of the spell of illness and the prior stay requirements.)

**210.2 Prior Inpatient Stay.**--In addition to the spell of illness requirement, the law further specifies that a patient is entitled to these home health visits under hospital insurance in the year following his most recent discharge from a covered stay of any duration in an extended care facility or from a stay of at least 3 consecutive days in:

1. a participating hospital, psychiatric hospital or tuberculosis hospital; or
2. a participating distinct part of a psychiatric or tuberculosis hospital; or
3. a nonparticipating hospital, psychiatric hospital, or tuberculosis hospital which meets at least the following requirements:
  - A. provides 24-hour nursing service rendered or supervised by a registered professional nurse and has a licensed practical nurse or registered professional nurse on duty at all times (§ 112.1E); and
  - B. where licensing of hospitals is provided for under State or local law, is licensed or approved by the State or local licensing agency as meeting the standards established for such licensing (§ 112.1G); and
  - C. is primarily engaged in providing to inpatients, by or under the supervision of doctors of medicine or osteopathy:

(1) diagnostic and therapeutic services for medical diagnosis, treatment and care of injured, disabled, or sick persons (§ 112.1A.1), or

(2) rehabilitation services for the rehabilitation of injured, disabled, or sick persons (§ 112.1A.2); and

D. is not primarily engaged in providing to inpatients skilled nursing care and related services for patients who require medical or nursing care. (See definition of an extended care facility in § 112.2.)

Nonparticipating psychiatric and tuberculosis hospitals need not meet the special requirements applicable to such hospitals to satisfy the prior stay requirements. Federal hospitals need not be licensed under State or local licensing laws to meet the prior stay hospital definition.

**NOTE:** Where the coverage of Part A home health services is dependent upon a nonparticipating hospital, psychiatric hospital, or tuberculosis hospital stay from which a patient was discharged **prior to January 1, 1968**, the following applies: the hospital must meet at least the conditions of participation for hospitals described in § 112.1 except requirements F, H, and I (the special requirements for tuberculosis and psychiatric hospitals need not be met).

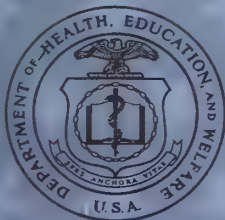




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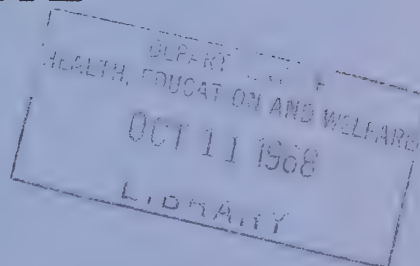
# HEALTH INSURANCE FOR THE AGED

# HOME HEALTH AGENCY MANUAL



U.S. DEPARTMENT OF  
HEALTH, EDUCATION, AND WELFARE  
SOCIAL SECURITY ADMINISTRATION

HIM-11 (9-68)







# Health Insurance for the Aged

## HOME HEALTH AGENCY MANUAL

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### USING THE HOME HEALTH AGENCY MANUAL

#### *Use It for Reference*

The manual covers not only routine information for your day-to-day operations but tries to anticipate infrequent situations that could occur. Use it for reference.

#### *Keep It Available*

Pages are punched for any standard-size 3-ring hardback binder. Keep it handy and ask for as many extra copies as you need.

#### *Keep It Up-to-Date*

Insert or replacement pages for additions and revisions will be furnished through your intermediary. Maintain a control on all manuals to assure immediate updating.

#### *Use Chapter Subjects*

A detailed index to facilitate locating of specific information will be sent later. The general subject listing for each chapter will help by giving designated section heads.



8-66 CHECK SHEET OF HOME HEALTH AGENCY MANUAL REVISION TRANSMITTALS

This Check Sheet should be placed at the front of the Manual immediately after the Foreword, to provide a record of Manual revisions received. These Manual revisions will be issued under cover of numbered "Revision Transmittals."

<u>Trans.</u> <u>No.</u>	<u>Date</u>	<u>Trans.</u> <u>No.</u>	<u>Date</u>
1.	<u>6/66</u>	21.	<u>          </u>
2.	<u>2/67</u>	22.	<u>          </u>
3.	<u>5/67</u>	23.	<u>          </u>
4.	<u>10/67</u>	24.	<u>          </u>
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6.	<u>4/68</u>	26.	<u>          </u>
7.	<u>5/68</u>	27.	<u>          </u>
8.	<u>6/68</u>	28.	<u>          </u>
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## FOREWORD

This manual is designed for use by home health agencies which will be billing for services furnished under the provisions of the Health Insurance for the Aged Act of 1965. It contains informational and procedural material the home health agency will need to assist in prompt and efficient payment of claims and to answer questions which patients may ask about the program. This issuance should help to assure that the law is uniformly applied nationally without regard to where covered services are furnished. This manual is not intended to supersede "The Conditions of Participation for Home Health Agencies." Both issuances are to be used for home health agency reference purposes. The home health agency's intermediary will issue any necessary supplementary instructions on matters which concern the relationship between agencies and intermediaries.

The manual does not have the effect of regulations, but a careful effort has been made to insure that the provisions of the law and proposed regulations are accurately reflected.

The procedures described in this manual have been devised to satisfy the administrative needs of the program with a minimum of inconvenience to beneficiaries, and to home health agencies and their intermediaries. We believe that the vast majority of claims will lend themselves to simple, routine handling.

The manual is designed to accommodate new pages as further interpretations of the law and changes in procedures are made. Accordingly, revised sections, pages or chapters will be issued as the need presents itself.

Your intermediary will answer any questions you may have about policies and procedures in the program. Home health agencies dealing directly with the Social Security Administration may direct any questions to the servicing social security district office for reply or refer them to the Bureau of Health Insurance Regional Representative.

ARTHUR E. HESS, *Director,*  
*Bureau of Health Insurance.*





## CHAPTER I

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## Chapter I

### GENERAL INFORMATION ABOUT THE PROGRAM

#### 100. INTRODUCTION

The Health Insurance for the Aged Act, Title XVIII of the Social Security Act has made available to nearly every American 65 years of age and older a broad program of health insurance designed to assist the Nation's elderly to meet hospital, medical, and other health costs. The program includes two related health insurance programs—hospital insurance (Part A of the law) and voluntary supplementary medical insurance (Part B of the law).

The conduct of the program has been delegated by the Secretary of Health, Education, and Welfare to the Commissioner of Social Security. Congress has provided substantial administrative roles for the States and for voluntary insurance organizations in recognition of their experience in the health care and insurance fields.

The law specifically prohibits the Federal Government from exercising supervision or control over the practice of medicine, the manner in which medical services are provided, and the administration or operation of medical facilities. The patient is free to choose any qualified institution, agency, or person offering him services. The responsibility for his treatment and the control of his care remains with his physician and the home health agency or other facility furnishing him services. The individual may keep or obtain any other health insurance he desires.

#### 102. DISCRIMINATION PROHIBITED

Participating providers of services under the hospital insurance program, i.e., hospitals, extended care facilities, and home health agencies, must comply with the requirements of Title VI of the Civil Rights Act of 1964. Under the provisions of that Act, a participating home health agency is prohibited from making a distinction on the ground of race, color, or national origin in the acceptance and treatment of patients; the services provided; the use of equipment and other facilities; and the assignment of personnel to provide services.

The Department of Health, Education, and Welfare is responsible for investigating complaints of noncompliance.

#### 104. DISCLOSURE OF INFORMATION

Records and information acquired in the administration of the Social Security Act are confidential and may be disclosed only under the conditions prescribed in regulations or on the express authorization of the Commissioner of Social Security. The regulations of the Department of Health, Education, and Welfare regarding the confidentiality of records and information apply not only to governmental agencies but also to public and private agencies participating in the administration of the program, as well as those institutions, facilities, agencies, and persons providing services, and those furnishing services under arrangements with a provider of services. However, the medical records of a patient (other than those obtained from the Social Security Administration) are the property of the home health agency and are not subject to these rules and regulations even though the patient receives benefits under this program. These records, however, may be subject to State or local laws or home health agency rules governing disclosure.

Disclosure by a provider of records or information is permitted when necessary in connection with a claim under health insurance and for the proper performance of the duties of any officer or employee of a public or private agency, or organization which has entered into an agreement with the Social Security Administration to carry out the health insurance provisions of the law.

Program information furnished by a provider of services to a State agency certifying providers in the health insurance program may, with the approval of the Department of Health, Education, and Welfare be disclosed by the State agency to the State licensing authority if the information relates to the provider's compliance or noncompliance with the licensure requirements.

Program information and records may not be disclosed to others not enumerated above except under the conditions prescribed by regulations.

#### 110. HOSPITAL INSURANCE—A BRIEF DESCRIPTION

Payment for the services and items provided under hospital insurance described below is always made directly to the provider of service; i.e., hospital, extended

care facility, or home health agency, on behalf of the patient. The amount of such payment is based on the reasonable cost to the provider for furnishing these covered services and items to the patient.

**110.1 Inpatient Hospital Services.**—The items and services covered include: bed and board in a semi-private (2 to 4 beds) accommodation, unless a private room is medically necessary; nursing and other related services; use of hospital facilities and medical social services ordinarily furnished by the hospital for the care and treatment of inpatients; drugs, biologicals, supplies, appliances, and equipment for use in the hospital, which are ordinarily furnished by the hospital; diagnostic or therapeutic items or services furnished by the hospital or by others under arrangements made by the hospital; services by interns or residents-in-training if they are under a teaching program approved by the American Medical Association, American Osteopathic Association, or American Dental Association; and cost of whole blood after the first 3 pints in a spell of illness and all costs of administering the blood.

The patient is entitled to payment on his behalf for up to 90 days of inpatient hospital services in each spell of illness. There is an inpatient hospital deductible of \$40 in each spell of illness and a coinsurance amount of \$10 per day after the 60th day and through the 90th day. The deductible and coinsurance amounts are subject to change on January 1, 1969, and on the first day of each odd year thereafter.

Inpatient tuberculosis hospital services are covered if the services furnished to the individual are services which can reasonably be expected to improve his condition or render it noncommunicable. Inpatient psychiatric hospital services are covered if the services furnished to the patient are furnished when he is receiving intensive treatment, or are necessary for medically required inpatient diagnostic study. Where an individual is in a qualified tuberculosis or psychiatric hospital on the first day of the first month for which he is entitled to hospital insurance benefits, the days on which he was an inpatient of such a hospital in the 90-day period immediately before his first day of entitlement must be counted in determining the 90-day limit on inpatient hospital services in his first spell of illness. In addition, there is a lifetime limitation of 190 days for payment for inpatient psychiatric hospital services. A period spent in a psychiatric hospital prior to entitlement, however, does not count against the 190 days.

**110.2 Outpatient Hospital Diagnostic Services.**—Outpatient hospital diagnostic services covered under hospital insurance include—

A. diagnostic tests and related services to the extent that they would not be excluded if performed on an inpatient basis;

B. drugs and biologicals necessary for diagnostic study;

C. the services rendered in connection with a diagnostic study by an intern or resident-in-training under an approved teaching program; and

D. other services and supplies if customarily furnished to outpatients for purposes of diagnostic study.

Benefits are payable on the basis of a diagnostic study period, which is a period of 20 consecutive days beginning with the first day, not included in a previous diagnostic study, on which the patient receives outpatient diagnostic services.

The deductible for outpatient hospital diagnostic services during each diagnostic study is one-half the inpatient hospital deductible, or \$20. This deductible amount counts as an incurred expense for individuals with supplementary medical insurance coverage. After satisfying the \$20 deductible, the patient is responsible for a coinsurance amount equal to 20 percent of the reasonable charges, not in excess of the amount customarily charged, for the outpatient hospital diagnostic services rendered during the diagnostic study.

**110.3 Posthospital Extended Care Services.**—A patient is entitled to up to 100 days of posthospital extended care services in a spell of illness. The patient must have been a hospital inpatient for at least 3 consecutive days before his discharge and must be admitted to the extended care facility within 14 calendar days after the date of hospital discharge. Benefits for posthospital extended care are payable for services furnished on or after January 1, 1967. Discharge from the hospital must occur after June 30, 1966, or on or after the first day of the month in which the beneficiary attains age 65, whichever is later. The program will pay the reasonable cost of services for up to 100 days in each spell of illness, except that there is a \$5 per day coinsurance amount for each day of extended care services after the first 20 days.

Covered services include room and board; skilled nursing care by or under the supervision of a registered professional nurse; physical, occupational, or speech therapy either by the extended care facility or under arrangements made by the facility; drugs, biologicals, supplies, appliances, and equipment furnished for use in the extended care facility which are ordinarily furnished for the care and treatment of inpatients; and other services ordinarily furnished by the facility. No payment may be made for custodial care or for items or services which would not be covered in a hospital, e.g., physicians' services and private duty nursing. The services of residents-in-training and interns under an approved teaching program of a hospital with which the facility has a transfer agreement (see § 112.2), and other diagnostic and therapeutic services furnished by such a hospital are covered if furnished under arrangements made by the facility.

**110.4 Posthospital Home Health Services.**—Home health services are provided under hospital in-



surance and also under supplementary medical insurance. (For a complete discussion of these services, see chapter II.)

## **112. HOSPITAL INSURANCE DEFINITIONS RELATING TO PART A HOME HEALTH SERVICES**

**112.1 Hospital.**—A hospital is an institution which—

A. is primarily engaged in providing, by or under the supervision of physicians, to inpatients—

1. diagnostic and therapeutic services for medical diagnosis, treatment, and care of injured, disabled, or sick persons, or

2. rehabilitation services for the rehabilitation of injured, disabled, or sick persons.

B. maintains clinical records on all patients;

C. has bylaws in effect concerning its staff of physicians;

D. has a requirement that every patient must be under the care of a physician;

E. provides 24-hour nursing service by or supervised by a registered professional nurse and has a licensed practical nurse or registered professional nurse on duty at all times;

F. has in effect a hospital utilization review plan;

G. is licensed or is approved by the State or local licensing agency as meeting the standards established for such licensing; and

H. meets other health and safety requirements of the Secretary of the Department of Health, Education, and Welfare. (These additional requirements may not be higher than comparable ones prescribed for accreditation by the Joint Commission on Accreditation of Hospitals with certain exceptions specified in the law.)

I. is not primarily for the care and treatment of mental diseases or tuberculosis.

**112.2 Extended Care Facility.**—An extended care facility is one which provides skilled nursing care and related services for patients who require medical or nursing care; or rehabilitation services for injured, disabled, or sick persons. It may be either a separate institution (such as a nursing home) or a part of an institution (such as a convalescent wing of a hospital), licensed or approved for licensing under State or local law, and meet the health and safety conditions prescribed by the Secretary of the Department of Health, Education, and Welfare. The extended care facility must have a written transfer agreement with one or more participating hospitals providing for the transfer of patients between the hospital and the facility and for the interchange of medical and other information. If an otherwise qualified facility has failed in an attempt, in good faith, to enter into such an agreement, the agreement requirement may be waived by the State agency. A facility primarily for the care and treatment of mental disease or tuberculosis may not qualify

as a participating extended care facility in the health insurance program.

Qualified facilities must enter into the required agreement with the Secretary to participate as providers of services in the health insurance program.

A patient can meet the prior stay requirement for "posthospital" home health services (see chapter II) by a covered stay in a participating extended care facility. See § 110.3 for the conditions of a covered stay.

**112.3 Spell of Illness Defined.**—A spell of illness is a period of consecutive days that **begins** with the first day (not included in a previous spell of illness) on which a patient is furnished inpatient hospital or extended care services by a qualified provider in a month for which the patient is entitled to hospital insurance benefits. A qualified hospital (including a psychiatric or tuberculosis hospital) or extended care facility is one that has been certified as meeting all the requirements of the definition of such an institution. A hospital which meets the requirements in the definition of a hospital except for F and H in § 112.1 is also a qualified hospital for purposes of beginning a spell of illness when such hospital furnishes the patient covered *inpatient emergency* services. **Thus, generally, the spell of illness begins when covered inpatient services are initially furnished to an entitled individual.**

The spell of illness **ends** with the close of a period of 60 consecutive days during which the patient was neither an inpatient of a hospital nor an inpatient of an extended care facility. In determining the 60-consecutive-day period, the day of discharge should be counted. **It is important to note that for purposes of continuing a spell of illness, the hospital or extended care facility in which the stay occurs need not meet all of the requirements that are necessary for starting a spell of illness.**

Inpatient services will prolong the beneficiary's spell of illness if the **hospital** is primarily engaged in providing, by or under the supervision of physician(s), to inpatients (1) diagnostic and therapeutic services for medical diagnosis, treatment, and care of injured, disabled, or sick persons, or rehabilitation services for injured, disabled, or sick persons; **or** (2) psychiatric services for the diagnosis and treatment of mentally ill persons; **or** (3) medical services for the diagnosis and treatment of tuberculosis.

Similarly, inpatient services in an **extended care facility** will prolong a beneficiary's spell of illness if the facility (including one primarily for the care and treatment of mental diseases or tuberculosis) meets at least the requirement that it is primarily engaged in providing to inpatients skilled nursing care and related services for patients who require medical or nursing care, or rehabilitation services for injured, disabled, or sick persons.

An individual may be discharged from and readmitted to a hospital or extended care facility several times during a spell of illness and still be in the same spell if 60 days have not elapsed between discharge and readmission. The stay need not be for related physical or mental conditions.

As long as a person continues to be entitled to hospital insurance, there is no limit to the number of spells of illness he may have.

**Example 1:** X was born August 9, 1902. On July 28, 1967, X entered a participating general hospital. After he had been in the hospital for 2 weeks X was discharged on August 11, 1967. On his doctor's orders X entered a participating nursing home on August 15, 1967, and remained there until his discharge on October 27, 1967. He had no further inpatient stays in 1967. X's spell of illness began on August 1, 1967, the first day of the month he attained age 65 and was entitled to hospital insurance. The spell of illness ended December 25, 1967, the end of the 60-day period beginning with the day of last discharge.

**Example 2:** Y, over age 65, entered a participating general hospital on July 28, 1968, for treatment of a heart condition. He was discharged on August 11, 1968. On August 20, 1968, Y entered a **nonparticipating nursing home**, which provided primarily skilled nursing care and related services. Y remained in this facility until his discharge on October 27, 1968. On December 25, 1968, Y was again admitted to a participating hospital because of injuries suffered in an accident. He was discharged on January 13, 1969, and had no further inpatient stays in 1969. Y's spell of illness began on July 28, 1968. His stay in the nursing home began less than 60 days after his hospital discharge and the spell was continued even though the stay was not covered. The subsequent hospital stay began less than 60 days after the nursing home discharge and continued the spell of illness although the condition treated was unrelated to his prior stays. The spell ended on March 13, 1969, the end of the 60-day period beginning with the day of last discharge.

## 115. SUPPLEMENTARY MEDICAL INSURANCE—A BRIEF DESCRIPTION

**115.1 Benefits.**—The voluntary medical insurance plan is designed to supplement the basic hospital insurance coverage. It provides coverage effective July 1, 1966, for (a) home health services (a full discussion of the coverage under this phase of the program is contained in chapter II), and (b) medical and other health services.

Medical and other health services include:

A. Physicians' services (see definition of "physician" below) including surgery, consultation, and home, office, and institutional calls.

Regardless of the actual expenses for physician serv-

ices incurred in the treatment of mental, psychoneurotic, or personality disorders of persons who are not inpatients of hospitals, the amount of such expenses that can be counted in a calendar year is limited to the lesser of \$312.50 or 62.5 percent of the actual expenses.

**Physician** means a doctor of medicine or osteopathy (including osteopathic practitioner) legally authorized to practice by a State in which he performs the function. A doctor of dental surgery or dental medicine having State authorization to practice is also defined as a physician but only with respect to surgery related to the jaw or any structure contiguous to the jaw, or the reduction of any fracture of the jaw or any facial bone. The services performed by physicians within these definitions are subject to any limitations imposed by the State on the scope of practice.

B. Services and supplies (including drugs and biologicals which cannot be self-administered) incident to physicians' professional services and of kinds commonly furnished by a physician in his office and which are commonly rendered without charge or included in his bill. The services include hospital services (including drugs and biologicals which cannot be self-administered) incident to physicians' services rendered to outpatients.

C. Diagnostic X-ray, laboratory, and other diagnostic tests.

D. X-ray, radium, and radioactive isotope therapy (including material and services of technicians).

E. Surgical dressings, and splints, casts, and other devices used for reduction of fractures and dislocations.

F. Rental (for use in the patient's residence, including an institution used as his home) of such durable medical equipment as iron lungs, oxygen tents, wheelchairs, and special beds.

G. Ambulance service, where the use of other transportation is contraindicated by the patient's condition. (Transportation service from place of residence to a facility to receive home health services on an outpatient basis is excluded.)

H. Prosthetic devices (other than dental) replacing all or part of an internal body organ, including replacement of such devices.

I. Leg, arm, back, and neck braces, and artificial legs, arms, and eyes, including replacements if required because of a change in physical condition.

**115.2 Basis for Payment.**—Payment, based on **reasonable charges**, may be made to or on behalf of individuals covered by medical insurance for services of physicians and other nonprovider services furnished under the plan. In determining the reasonableness of charges the carrier takes into consideration the customary charges of the physician (or other person rendering the service) as well as the prevailing charges in the locality generally made for similar services. A



charge is not reasonable if it is higher than the charge applicable for a comparable service and under comparable circumstances to the intermediary's own policyholders or subscribers.

Payment for services rendered by or under arrangements made by a home health agency or other provider of services under medical insurance is based on the **reasonable cost** of the services and is made only to the provider of services. This is the same basis for reimbursement as under the hospital insurance plan and accords with the provider's undertaking in the participation agreement to accept reasonable cost as full payment for services rendered.

**115.3 Deductible and Coinsurance.**—There is a deductible consisting of the first \$50 of covered incurred expenses in a calendar year (expenses applied toward the deductible in the last 3 months of a year may also be applied toward the deductible in the following year). After the deductible has been satisfied, payment by the supplementary medical insurance program will be made for 80 percent of the reasonable charge or cost.

## 120. ENTITLEMENT TO HOSPITAL INSURANCE

A. An individual is **automatically** entitled to hospital insurance beginning with the first day of the month he attains age 65 if he has applied for and been determined to be entitled to monthly social security benefits (although he may not actually be receiving benefit payments, e.g., he has not retired). Automatic entitlement also extends to qualified beneficiaries under the Railroad Retirement Act. (For social security purposes, a person attains age 65 on the day before his 65th birthday.) Example: If birth date is August 1, attainment date is July 31, and health insurance entitlement date is July 1.

A social security applicant who applies for monthly benefits after the month he reaches age 65 is entitled to retroactive hospital insurance benefits beginning with the first month in which he had attained age 65 and met all the requirements for monthly benefits, but not for more than 12 months before the month in which he filed his application.

Entitlement to hospital insurance benefits ends with the month the individual ceases to be entitled to social security monthly benefits or ceases to be a qualified railroad beneficiary (for example, a woman whose wife's benefits are terminated by divorce). A person who ceases to be a social security or railroad retirement beneficiary but who meets the requirements of the special transitional provision described below may reinstate his hospital insurance by filing a proper application under the transitional provision.

Hospital insurance coverage continues for the month of death, although no monthly cash benefits are payable for that month.

B. A special **transitional** provision in the law permits persons 65 years of age and over, who cannot qualify for monthly social security or railroad retirement benefits, to obtain hospital insurance upon filing application. Such an individual must be a resident of the United States and either a citizen or an alien lawfully admitted for permanent residence who has resided in the United States continuously for 5 years. He may not be an active or retired Federal employee (or spouse of one) who is or could have been covered by the Federal Employees Health Benefit Act of 1959. He may not be a member of a communist organization nor have been convicted of a crime against the security of the United States.

For coverage under the transitional provision, a person attaining age 65 after 1967 must have three quarters of coverage for each year elapsing between 1965 and the year in which he attains age 65.

Hospital insurance under the transitional provision can also be retroactive for as many as 12 months before the month of application, provided the individual meets all the other requirements during the period of retroactivity.

## 122. ENTITLEMENT TO SUPPLEMENTARY MEDICAL INSURANCE

A. **Enrollment.** To obtain supplementary medical insurance coverage an individual must voluntarily enroll in the plan and pay the required premiums. He is eligible to enroll if he is entitled to hospital insurance benefits or is 65 years of age and otherwise meets the requirements for hospital insurance coverage under the transitional provision of the law. Active or retired Federal employees and their spouses are eligible to enroll whether or not covered under the Federal Employees Health Benefit Act. (For social security purposes an individual attains age 65 on the day before his 65th birthday.)

By agreement, States may enroll in the supplementary medical insurance plan eligible individuals who are receiving money payments under certain public assistance programs. Such persons who are entitled to monthly social security or railroad retirement benefits may be included at the option of the State.

B. **Enrollment Periods.** Enrollment is possible only during specified enrollment periods.

1. During the **initial general enrollment period** an opportunity to enroll was afforded to all eligible persons age 65 and over before March 1, 1966. This enrollment period ended May 31, 1966. (An eligible individual who for good cause failed to enroll before June 1, 1966, may enroll before October 1, 1966.)

2. For persons first eligible on or after March 1, 1966, the **initial enrollment period** is 7 months. It begins 3 calendar months before and ends 3 calendar months after the month in which the individual first meets all enrollment requirements.



3. **General enrollment periods** occur October 1 through December 31 of each odd-numbered year beginning with 1967. Those who failed to enroll during their initial enrollment periods and those whose enrollment has terminated may enroll in these periods.

4. **States which desire to enroll eligible individuals receiving public assistance** must request coverage before January 1968, and enter into an agreement with the Government.

An individual who fails to enroll for medical insurance within the 3-year period after the close of his initial enrollment period may not enroll thereafter.

An individual whose enrollment has terminated may re-enroll only once—in a general enrollment period which begins within 3 years after the termination of his prior enrollment.

Payment may be made for covered services if the individual was enrolled at the time the services were furnished, even though at the time the request for payment is filed with the intermediary his enrollment had been terminated.

**122.1 Premiums.**—Initially, the premium is \$3 per month. The law permits the Secretary of Health, Education, and Welfare to adjust the premium amount if medical costs rise. No increase in the premium is permitted before 1968, and increases thereafter can be no oftener than every 2 years. To take into account the higher cost of insuring older individuals, premiums payable by a person who enrolls after the first enrollment period open to him, or who re-enrolls after his initial enrollment was terminated, are increased by 10 percent for each year he could have been but was not enrolled.

A grace period has been provided for payment of premiums. This period extends for 2 calendar months after the month in which the premium is due.

Social security and railroad retirement beneficiaries and civil service annuitants (except those enrolled by the State as public assistance recipients) who elect to enroll will have the premiums withheld from their monthly checks. The State pays the premiums for the public assistance recipients it enrolls.

Other enrollees must make premium payments directly to the Social Security Administration. Enrollees who make direct premium payment will generally be billed quarterly. However, State or local government organizations, employers, unions, or other organizations may under certain conditions pay premiums for their members as a group.

### 122.2 Beginning of Coverage

A. Enrollment during the initial general enrollment period—coverage begins July 1, 1966.

B. Enrollment during an entitled individual's initial enrollment period—coverage begins:

1. First day of the month in which the individual becomes age 65, if he enrolls **before** the month that he becomes 65.

2. First day of the month following the month that he becomes age 65, if he enrolls **in** the month that he becomes 65.

3. First day of the second month after the month of enrollment, if he enrolls in the month **after** he became age 65.

4. First day of the third month after the month of enrollment, if he enrolls **more than one month after** the month in which he became age 65. (However, individuals who become age 65 in March 1966, and enroll in May 1966, will have coverage effective July 1, 1966).

C. Enrollment during one of the general enrollment periods—coverage begins the following July 1.

D. Enrollment by a State of its welfare recipients—coverage begins on the latest of the following but not later than January 1, 1968:

1. July 1, 1966;

2. First day of the third month after the month of the agreement with the State;

3. First day of the first month in which the individual is both eligible and a member of the group.

4. The date specified in the agreement.

### 122.3 End of Coverage

A. An individual whose medical insurance premiums are being deducted may notify the Social Security Administration in writing during a general enrollment period that he no longer wants medical insurance. His coverage period will be terminated with the close of the year in which his notice is submitted.

B. Enrollment under medical insurance is terminated because of nonpayment of premiums. Termination is effective with the end of the grace period provided for payment of premiums.

C. If an individual is enrolled under a Federal-State agreement, his coverage under the agreement ends on whichever of the following first occurs:

1. The end of the month in which he becomes ineligible (as determined by the State) for welfare money payments; or

2. The end of the month before the first month for which he becomes entitled to monthly social security or railroad retirement benefits, unless the State exercises its option to enroll such welfare recipients; or

3. The month in which the agreement terminates.

If an individual's coverage under a Federal-State enrollment agreement is terminated, his coverage continues without interruption if he is a social security or railroad retirement beneficiary or continues payment of premiums.

D. An individual will have coverage through the month in which he dies.

### 130. FEDERAL GOVERNMENT ADMINISTRATION OF THE HEALTH INSURANCE PROGRAM

The Department of Health, Education, and Welfare has been given overall responsibility for administration of the hospital insurance and voluntary supplementary medical insurance programs. Three major agencies of the Department—the Social Security Administration, Public Health Service, and Welfare Administration—are involved.

**130.1 The Social Security Administration** has the responsibility for policy formulation and the general management and operational aspects of the program. Briefly, these include: determination of the individual's entitlement to benefits and the nature and duration of services for which benefits may be paid; establishment, maintenance, and administration of agreements with State agencies, providers of services and intermediaries; in consultation with the Public Health Service and the Welfare Administration, the formulation of major policies regarding conditions of participation for providers; the development and maintenance of statistical research and actuarial programs; and the general financial management of the program. The Administration also makes determinations of reasonable costs and amounts to be paid to providers who have elected to deal directly with the Government.

**130.2 The Public Health Service** has the principal responsibility for the professional health aspects of the program. These include: professional consultation and recommendation to the Social Security Administration in development of health and safety, and other guidelines for determining whether providers of services meet the conditions for participation under the program; consultation and advice to State agencies concerning the application of standards for providers, and in the coordination of program activities with other health services and activities in the State; and activities necessary in studying the utilization of hospital and other medical care services under the program.

**130.3. The Welfare Administration** has the primary role in hospital and medical insurance program planning, coordination, and evaluation in matters that affect other federally aided assistance programs; in assisting State agencies to achieve a coordinated approach with other medical care plans under the Social Security Act; and in all aspects of program administration affecting public welfare agencies.

### 131. ADVISORY GROUPS

The law provides for the appointment of two non-Governmental advisory groups to assist the Secretary.

**131.1 The Health Insurance Benefits Advisory Council**, consisting of persons outstanding in hospital,

medical, and other health activities, and at least one representative of the general public, advises the Secretary on general policy in administering the program and in the formulation of regulations. The Secretary must consult with the Council in determining conditions of participation for providers of services in addition to the requirements specifically enumerated in the law.

**131.2 The National Medical Review Committee** is to be selected from people who are representative of professional organizations and associations in the field of medicine and other individuals who are outstanding in the field of medicine or in related fields. At least one member will represent the general public and a majority of the committee are physicians. The committee studies the utilization of hospital and other medical services under the program and makes any recommendations to the Secretary and to Congress that it considers appropriate.

### 132. STATE AGENCIES

The States are accorded important administrative functions to the extent that each is willing and able to undertake them by agreement with the Secretary.

**A. Certifications** are made by State agencies to the Department of Health, Education, and Welfare indicating whether hospitals, extended care facilities, home health agencies, and independent laboratories meet and continue to meet their respective conditions of participation. This function is intended to be a natural adjunct to ongoing State activities, such as licensing of health facilities and other standard setting activities.

**B. Consultation** services are rendered by State agencies if their agreements provide for it. Consultation with hospitals, extended care facilities, and home health agencies that need and request assistance to meet the conditions of participation is an integral part of the certification process.

**C. Coordination** by the State relates its activities in the performance of its functions under the program to the various other programs in the State that have to do with payment for health care, quality of care, and distribution of health facilities. Coordination of such activities is designed effectively and economically to utilize existing State facilities and trained personnel and to prevent duplication of effort.

**D. State Agency as a Medical Insurance Intermediary.**—Where a State enters into an agreement with the Government to pay the medical insurance premium on behalf of its aged welfare recipients, as explained in 122B of this chapter, the agreement may provide for a designated State agency to serve as an intermediary on behalf of its welfare recipients.

### 135. HOSPITAL INSURANCE INTERMEDIARIES

Under the hospital insurance plan, groups or associations of providers, on behalf of their members, may



nominate a national, State, or other public or private agency, or organization to serve as intermediary in the claims process. A member of an association is free, however, to receive payment from an approved intermediary other than its association's nominee, if agreeable to the Social Security Administration and to the intermediary selected. A provider may deal directly with the Social Security Administration.

The law permits the Administration to enter into an agreement with a nominated organization if it finds this to be consistent with effective and efficient administration of the hospital insurance program. The intermediary makes payments to providers for covered items and services on the basis of reasonable cost determinations and assists in the application of safeguards against unnecessary utilization of covered services. The agreement may also call for furnishing consultative services to assist providers to establish and maintain necessary fiscal records and otherwise qualify as providers of services; serving as a center for communicating with providers; and making audits of provider records.

Generally speaking, the Social Security Administration will utilize the services of the hospital insurance intermediary in making payments for home health and other provider services under medical insurance.

#### **137. MEDICAL INSURANCE CARRIERS**

The law requires the Secretary to enter into contracts with carriers selected to serve as intermediaries for the performance of specified administrative functions under the medical insurance program. The prin-

cipal function of this intermediary is to determine whether physicians' charges are reasonable and to make payment. Section 134D of this chapter explains the conditions under which a State agency may act as a supplementary medical insurance intermediary.

#### **140. FINANCING HOSPITAL INSURANCE PROGRAM**

The hospital insurance program is financed through separate payroll contributions paid by employees, employers, and self-employed persons. The proceeds are earmarked for the Federal Hospital Insurance Trust Fund to keep them separate from other social security contributions. The law permits their use only for the payment of hospital insurance benefits and administrative expenses. The cost of providing hospital insurance benefits to persons who are not social security or railroad retirement beneficiaries is met by appropriations to the Federal Hospital Insurance Trust Fund from general revenues.

#### **142. FINANCING SUPPLEMENTARY MEDICAL INSURANCE PROGRAM**

The supplementary medical insurance plan is financed by the monthly premiums of those who enroll under the plan, matched by an equal contribution from general revenues. All premiums and Government contributions for this plan are placed in a separate fund known as the Federal Supplementary Medical Insurance Trust Fund. This fund is devoted exclusively to the payment of medical insurance benefits and administrative expenses.



Podiatrists' Services

H115.1 Podiatrists as Physicians.--Effective January 1, 1968, coverage of physicians' services is extended to include services performed by podiatrists. The intent of the amendments is to allow payment for certain foot care services whether furnished by a doctor or medicine, osteopathy, or podiatry (to the extent that each is legally authorized to perform the services). Certain foot care services (including routine care), however, are excluded regardless of who performs them. (See § H233.)

A. Scope of Coverage of Podiatrists' Services.--Podiatrists (chiroprodists) are included within the definition of "physician" (except as indicated in B. below) but only with respect to those functions which they are legally authorized to perform in the State in which they perform them. This means that the professional services provided by a podiatrist within the scope of his applicable State license (except those services which are specifically excluded) are "physicians' services," reimbursable on a reasonable charge basis under Part B.

Podiatrists may hold any of the following professional degrees, of which the first three are the most common: Pod.D or D.P. (Doctor of Podiatry), D.S.C. (Doctor of Surgical Chiropody), D.P.M. (Doctor of Podiatric Medicine), D.S.P. (Doctor of Surgical Podiatry), Graduate in Podiatry, Master Chiroprodist, or in a very few instances another podiatry degree. Within a particular State, all individuals holding any of these degrees are licensed to perform the same functions; however, there are variations from State to State as to the authorized scope of podiatric practice.

B. Services for Which Podiatrists Are Excluded From the Definition of Physician.--

1. Physician Certification and Recertification of the Need for Provider Services (§ 240).--A podiatrist is not a "physician" for the purpose of making the required physician certifications and recertifications of the medical necessity for Part A and Part B provider services. This means that a medical doctor (or osteopath) must complete the certification of necessity for provider services where such certifications are required. However, no certification by a medical doctor is required with respect to a podiatrist's professional services to his patients.

2. Home Health Services Requirements (ss 200ff and 205).---A podiatrist is not a "physician" for the purpose of any of the physician activities required to qualify an organization as a home health agency or required for coverage of home health services. Thus, a podiatrist may not be a "physician" member of the group of professional personnel responsible for establishing policies governing the services provided by the home health agency, nor may a podiatrist furnish any of the "physician" supervision of the agency's services required by the statute or the Conditions of Participation for Home Health Agencies. In addition, a podiatrist is not a "physician" for the purpose of establishing or reviewing the plan of home health treatment required for each patient receiving covered services nor for the purpose of satisfying the requirement that each home health patient must be under the care of a "physician."

Hospital Insurance Benefits Entitlement

HI20 B. Transitional Provision.--The 1967 amendments modify the quarters of coverage requirement of the transitional provision. The person attaining age 65 after 1967, who is not entitled to monthly benefits under social security or railroad retirement, will need three less quarters of coverage than under the pre-amendment provision. A person attaining age 65 in 1968 needs 3 quarters of coverage; in 1969, 6 quarters of coverage; in 1970, 9 quarters of coverage; etc.

Supplementary Medical Insurance Benefits

HI22 A. Enrollment.--The 1967 amendments provide that States will be given the option of "buying-in" for all their aged who are eligible for medical assistance under Title XIX, whether or not they are receiving cash assistance.

B3 General Enrollment Period.--The first general enrollment period was to occur October 1, 1967, through December 31, 1967. By special Congressional action, however, this period was extended through March 31, 1968. The 1967 amendments provide that effective January 1, 1969, the general enrollment period will be annual rather than biennial and will run from January 1 through March 31 rather than October 1 through December 31. Coverage will begin on the following July 1.

B4 States.--The 1967 amendments extended from December 31, 1967, to December 31, 1969, the deadline by which States may request an agreement with the Secretary to enroll eligible individuals under the "buy-in" provision. States are also permitted to cover under the agreement persons who attain age 65 and otherwise become eligible after the December 31, 1969, deadline.

HI22.1 Premiums.--Through March 1968, the individual supplementary medical insurance premium was \$3. The law permitted the Secretary of Health, Education, and Welfare to adjust the premium amount consistent with changes in costs of the program, and in December 1967, the Secretary announced a new premium rate of \$4 effective April 1968 through June 1969.

With the 1967 amendments, the law specifies that the Secretary will determine and make known during December of each year the premium rate which will be applicable for a 12-month period to begin the following July 1. When the Secretary makes known a rate change for



Part B, he will issue a public statement setting forth the actuarial assumptions and other bases upon which he arrived at the new rate.

#### HL22.2 Beginning of Coverage

D. Enrollment by a State of its welfare recipients under the 1967 amendments--coverage begins on the latest of the following:

1. July 1, 1966.(no change)
2. First day of the third month after the month the modification or agreement is entered into. (no change)
3. First day of the first month in which the individual is eligible and a member of the group except that (for a State which buys in for medically indigent persons) if the individual is not in such month receiving money payments under titles I, IV(Part A), X, XIV, or XVI, his coverage will begin on the first day of the second month after such month, or on the first day of the first month in which he receives a money payment under one of the above titles, whichever occurs first. (1967 amendments)
4. The date specified in the agreement.

HL22.3A Coverage Ends.--Prior to the 1967 amendments, an individual could request termination of medical insurance by notifying the Social Security Administration in writing during a general enrollment period and coverage would terminate at the close of the general enrollment period. Because of the extension of the 1967 general enrollment period to April 1, 1968, coverage might end on either December 31, 1967, or March 31, 1968, the effective termination date being determined by the period during which the termination request was filed.

The 1967 amendments provide that beginning April 1, 1968, an individual wishing to disenroll ~~may~~ do so at any time, but such disenrollment will not take effect until the close of the calendar quarter following the calendar quarter in which the notice of disenrollment is filed.

C. If an individual is enrolled under a Federal-State agreement, his coverage under the agreement ends on whichever of the following occurs first:

1. The end of the month in which he becomes ineligible (as determined by the State) for welfare money payments or (if the agreement covers all individuals eligible for medical assistance under title XIX), for both money payments and medical assistance. (1967 amendments.)

2. The end of the month before the first month for which he becomes entitled to monthly social security or railroad retirement benefits (if the State's agreement covers only money recipients who are not entitled to such benefits).

3. The end of the month in which the State agreement is terminated.

4. The end of the month in which the individual dies.





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## Chapter II

### COVERAGE OF HOME HEALTH SERVICES

#### 200. HOME HEALTH AGENCY

A home health agency is a public agency or private organization, or a subdivision of such an agency or organization, which meets the following requirements:

A. It is primarily engaged in providing skilled nursing services and other therapeutic services, such as physical, speech, or occupational therapy, medical social services, and home health aide services. A public or voluntary nonprofit health agency may qualify by—

1. furnishing both skilled nursing and at least one other therapeutic service directly to patients, or
2. furnishing directly either skilled nursing services or at least one other therapeutic service and having arrangements with another public or voluntary nonprofit agency to furnish the services which it does not provide directly.

A proprietary agency can qualify only by providing directly both skilled nursing services and at least one other therapeutic service.

B. It has policies established by a professional group associated with the agency or organization (including at least one physician and at least one registered professional nurse) to govern the services, and provides for supervision of such services by a physician or a registered professional nurse.

C. It maintains clinical records on all patients.

D. It is licensed in accordance with State or local law or is approved by the State or local licensing agency as meeting the licensing standards (where State or local law provides for the licensing of such agencies or organizations).

E. It meets other conditions found by the Secretary of Health, Education, and Welfare to be necessary for health and safety.

A private organization which is not exempt from Federal income taxation under section 501 of the Internal Revenue Code of 1954 (sometimes referred to as a "proprietary" organization) must be licensed pursuant to State law. If the State has no licensing law for such organizations, a proprietary agency cannot participate in the health insurance program.

For services under hospital insurance, the term "home health agency" does not include any agency or organization which is primarily for the care and treatment of mental disease. There is no such restriction under supplementary medical insurance.

**200.1 Subdivision of Agencies.**—When the subdivision of an agency, such as the home care department of a hospital or the nursing division of a health department, wishes to participate as a home health agency, the subdivision must meet the conditions of participation and must maintain records in such a way that subdivision activities and expenditures attributable to services provided under the health insurance program are identifiable.

#### 200.2. Arrangements by Home Health Agencies

A. Arrangements made by a home health agency with others to furnish items or services must be such that receipt of payment by the home health agency for the services (whether in its own right or as agent) discharges the liability of the beneficiary or any other person to pay for the services.

Whether the services and items are furnished by the home health agency itself or by another agency under arrangements made by the home health agency, both must agree not to charge the patient for covered services and items and must also agree to return money incorrectly collected.

There are 3 situations in which a home health agency may have arrangements with another health organization or person to provide home health services to patients:

1. Where an agency or organization, in order to be approved to participate in the program, makes arrangements with another agency or organization to provide the nursing or other therapeutic services which it cannot provide directly.

2. Where an agency or organization, which is already approved for participation, makes arrangements with others to provide services it does not provide.

3. Where an agency or organization, which is already approved for participation, makes arrangements with a hospital, extended care facility, or rehabilitation center for services on an outpatient basis because the services involve the use of equipment which cannot be made available to the patient in his place of residence.

**B. If an agency's subdivision** (acting in its capacity as a home health agency) makes an arrangement with its parent agency for the provision of these items and/or services there need not be a contract or formal agreement. If, however, the arrangement is made between the home health agency and another provider participating in the health insurance program (hospital, extended care facility, or home health agency), there must be a written statement regarding the services to be provided and the financial arrangements.

**C. If the arrangements are with an agency or organization which is not a qualified provider of services**, there must be a written contract which includes all of the following:

1. A description of the services to be provided.
2. The duration of the agreement and how frequently it is to be reviewed.
3. A description of how personnel will be supervised.
4. A statement that the contracting organization will provide its services in accordance with the plan of treatment established by the patient's physician in conjunction with the home health agency's staff.
5. A description of the contracting organization's standards for personnel, including qualifications, functions, supervision, and inservice training.
6. A description of the method of determining reasonable costs and reimbursements by the home health agency for the specific services to be provided by the contracting organization.
7. An assurance that the contracting organization will comply with Title VI of the Civil Rights Act.

**200.3 Rehabilitation Centers.**—When the services are of such a nature that they cannot be administered at the patient's residence and are administered at a rehabilitation center which is not participating in the program as a hospital, extended care facility, or home health agency, the rehabilitation center must meet certain standards. The physical plant and equipment of such a rehabilitation center must meet all applicable State and local legal requirements for construction, safety, health, and design, including safety, sanitation and fire regulations, building codes, and ordinances.

## 205. COVERED HOME HEALTH SERVICES

A patient may be eligible for home health service under both hospital insurance and supplementary medical insurance. All services furnished by a home health agency, whether provided directly by the home health agency or under arrangements with others, must be furnished by or under the supervision of qualified personnel. The salaries of home health agency personnel employed to assist in the overall operation of the program, such as psychologists, inhalation therapists, and nutrition personnel, are includable in computing the agency's reimbursable costs. However, payment may not be made for individual visits by such personnel to a beneficiary's home, and if such a visit is made, it would not count against the beneficiary's "visit" limitation.

The following sections discuss covered home health services under both programs when provided by the home health agency, or by others under arrangements with the home health agency.

**205.1 Nursing care** is covered when provided on a part-time or intermittent basis.

**A. Registered and Practical Nurses.**—Nursing care is professional nursing service provided by a registered professional nurse in accordance with a physician's orders, or the practical nursing service provided by either a licensed practical or licensed vocational nurse (these terms may be used interchangeably) working under the supervision of a registered professional nurse. (See "Conditions of Participation for Home Health Agencies" for qualifications required for nurses.)

**B. Student Nurses.**—If a home health agency participating in the training of **student nurses** assigns a student nurse to provide nursing services in the patient's home, the costs of her services are reimbursable if the following conditions are met:

1. The student nurse is enrolled in a diploma or baccalaureate degree program approved by the National League for Nursing (a registered professional nurse receiving additional training is not considered a student nurse); and
2. The student nurse's services are "skilled nursing services" as defined in the "Conditions of Participation for Home Health Agencies" except when the lack of a license limits her activities; and
3. Her services are performed under the supervision of a registered professional nurse who is either an employee of the home health agency or the school of nursing in which the student is enrolled. The supervising nurse need not accompany the student on each visit. (See § 218.2 for counting of visits when



the supervisor accompanies the student on a visit.)

**C. Part-Time or Intermittent Services.**--Part-time or intermittent service of professional personnel and home health aides is usually service for a few hours a day several times a week. Occasionally, more service, i.e., 8 hours, may be provided for a limited period when the physician recommends and, when because of unusual circumstances, neither the alternative of part-time care nor institutionalization is feasible.

Services of **professional staff** usually are provided less frequently and for shorter periods of time than are the services of home health aides. For physical, speech, and occupational therapists and medical social workers, visits ordinarily should not exceed 1 hour.

**Home health aide visits** usually will be provided two or three times a week for several hours. Thus most agencies average 20 hours or less a week for the Medicare case load. This average reflects the planning and flexibility needed to provide up to 8 hours a day, 5 days a week for the few very ill patients who need extensive care and have no family member present during the day.

In recognition of the span of normal practice followed in home care, reimbursement may ordinarily be made for up to 100 hours a month of home health aide service assuming no question exists regarding the coverage status of such services. By the same token, on an intermittent basis, service for up to 8 hours a day, 5 days a week may be provided when medically necessary due to unusual circumstances, e.g., the patient has just returned from the hospital and must be oriented, along with his family, to various aspects of home care; the patient's condition is terminal; or he has suffered a relapse which while requiring more intensive care either does not necessitate institutionalization or institutionalization cannot immediately be arranged. The agency will need to explain for patients having service exceeding a rate of 100 hours per month, why this amount of care was required.

**205.2 Physical, Speech, and Occupational Therapy.**--Physical, speech, and occupational therapy furnished by the home health agency is covered when provided in accordance with a physician's orders and by or under the supervision of a qualified therapist.

The cost of the services of aides and other personnel providing supplementary services is covered when such an aide or other person is trained and supervised by appropriate professional personnel.

**205.3 Medical Social Services.**--These services must be under the direction of a physician and must be given by or under the supervision of a qualified medical or psychiatric social worker.

**205.4 Services of a Home Health Aide.**--The primary function of a home health aide is the personal care of a patient. The services of a home health aide are given under the supervision of a registered professional nurse, and if appropriate, a physical, speech, or occupational therapist. The assignment of a home health aide to a particular case must be made in accordance with a written plan of treatment established by a physician which indicates the patient's need for personal care services. The specific personal care services to be provided by the home health aide must be determined by a registered professional nurse and not by the home health aide.

Personal care duties which may be performed by a home health aide include assistance in the activities of daily living, e.g., helping the patient to bathe, to get in and out of bed, to care for his hair and teeth, to exercise, and to take medications specifically ordered by a physician which are ordinarily self-administered, and retraining the patient in necessary self-help skills.

While the primary need of the patient for home health aide services furnished in the course of a particular visit may be for personal care services furnished by the aide, the home health aide may also perform certain household services which are designated to the home health aide in order to prevent or postpone the patient's institutionalization. These services may include keeping a safe environment in areas of the home used by the patient, e.g., changing the bed, light cleaning, rearrangements to assure that the beneficiary can safely reach necessary supplies or medication, laundering essential to the comfort and cleanliness of the patient, etc., seeing to it that the nutritional needs (which may include the purchase of food and assistance in the preparation of meals) of the patient are met, and washing utensils used in the course of the visit. If these household services are incidental and do not substantially increase the time spent by the home health aide, the cost of the entire visit would be reimbursable. Housekeeping services which would materially increase the amount of time required to be spent by the home health aide to make the visit above the amount of time necessitated by care for the patient are not reimbursable. Where another member of the household is an equally aged and feeble or ill person, e.g., an aged spouse or parent of the beneficiary, certain services performed by the home health aide may be advantageous to both members



of the household but would nevertheless be reimbursable if the amount of time spent by the aide is not materially increased in order to serve the nonbeneficiary member.

The discussion of part-time or intermittent services in § 205.1C is also applicable to home health aides.

**205.5 Medical Supplies (Except for Drugs and Biologicals) and the Use of Medical Appliances.**--Medical supplies are items which are essential to enable the home health agency to carry out effectively in the home the kinds of care which the physician has ordered. Medical supplies include (but are not limited to) gauze, cotton, adhesive bandage, surgical dressings, catheters, surgical gloves, rubbing alcohol, irrigating solutions, intravenous fluids, and oxygen.

Medical appliances are items owned or rented by the home health agency and loaned to the patient to facilitate his treatment and rehabilitation. They include, but are not limited to, such items as bedpans, wheelchairs, crutches, hospital beds, trapeze bars, oxygen tents, intermittent positive pressure machines, and air pressure mattresses.

Drugs and biologicals are excluded from coverage as items or services administered by home health agencies, under either hospital insurance or medical insurance. They may, in certain cases, be covered under medical insurance when administered by a physician as a part of his professional services and are not capable of being self-administered.

**205.6 Services of Interns and Residents.**--Home health services include the medical services of interns and residents-in-training under an approved hospital teaching program (if the agency has an affiliation with or is under common control of a hospital providing such medical services). "Approved" means approved by the Council on Medical Education of the American Medical Association, or in the case of an osteopathic hospital, the Committee on Hospitals of the Bureau of Professional Education of the American Osteopathic Association, and, in the case of an intern or resident-in-training in the field of dentistry, approved by the Council on Dental Education of the American Dental Association. Reimbursement is provided under Part B for the services other hospital interns and residents furnish to beneficiaries receiving home health services.

**205.7 Outpatient Services.**--Outpatient services include any of the items or services described above which are provided under arrangements on an outpatient basis at a hospital, extended care facility, rehabilitation center, or outpatient department affiliated with a medical school, and (1) which require equipment which cannot readily be made available at the patient's place of residence or (2) which



are furnished while he is at the facility to receive the services described in (1). The hospital, extended care facility, or outpatient department affiliated with a medical school must all be qualified providers of services. However, there are special provisions for the use of the facilities of rehabilitation centers (see § 200.3). The cost of transporting an individual to a facility cannot be reimbursed as a home health service.

#### 208. CONDITIONS FOR COVERAGE FOR HOME HEALTH SERVICES UNDER BOTH HOSPITAL AND MEDICAL INSURANCE

**208.1 Patient Must be Under Care of a Physician.**--Items and services must be furnished to an individual who is under the care of a physician. This physician may be the patient's private physician; or, a physician on the staff of the home health agency; or, a physician working under an arrangement with the institution which is the patient's residence; or if the agency is hospital-based, a physician on the hospital or agency staff. The attending physician establishes the plan of treatment and also certifies to the necessity for home health services.

**208.2 Services Furnished by Agency.**--Items and services must be furnished by a participating home health agency or by others under arrangements made by the agency. (See § 200.2 for definition of "under arrangements.")

**208.3 Services Furnished Under a Plan.**--Items and services must be furnished under a plan established and periodically reviewed by a physician and which relates the items and services to the patient's condition. A plan must be reduced to writing by the physician and be made available to the home health agency which has accepted the patient as a client. (See § 210.3 for coverage of Part A services rendered before the plan is reduced to writing.) Part B home health services furnished before the plan is reduced to writing are covered if authorized by a physician. However, the plan is to be reduced to writing prior to the submission of the bill. The plan should specify the types of services required and should, as far as possible, provide a long-range forecast of likely changes in the patient's condition. It should include the diagnosis and a description of the patient's functional limitation resulting from the illness or injury, the type and frequency of nursing services needed, drugs and medications, special diets, activities permitted, rehabilitation and therapy services, medical social services, home health aide services, and the medical supplies and appliances necessary.

The plan is signed by the attending physician and incorporated into the agency's permanent record for the patient. Any changes should be

made in writing and signed by the physician or by a registered professional nurse on the staff of the agency pursuant to the physician's oral orders. All changes in orders for dangerous drugs and narcotics must be signed by the physician.

The plan must be reviewed by the attending physician, in consultation with agency professional personnel, at such intervals as the severity of the patient's illness requires but at least every 2 months. Each review of a patient's plan should contain the initials of the physician and show the date performed. The agency's record need not be forwarded to the intermediary for review but will be retained in the agency's file.

When an individual has coverage under both Part A and Part B, home health plans under both parts should not operate concurrently. For example, a plan of treatment is established after hospitalization for a condition for which the patient was hospitalized, and the patient later requires home health services for a condition unrelated to the previous hospitalization but while the original plan of treatment is still in effect. The original plan of treatment should be modified to take into account the required home health services for the condition not related to previous hospitalization. Otherwise, there would be administrative difficulties in counting home health visits, particularly if two home health agencies become involved. Of course, if the patient does not have Part B coverage, the original plan of treatment cannot be modified to provide home health services not related to prior hospitalization.

When benefits under hospital insurance have been exhausted and a change to benefits under medical insurance is made, it is not necessary for the physician to change the plan of treatment.

**208.4 Patient Confined to His Home.**--In order for a beneficiary to be eligible to receive covered home health services under both Part A and Part B, the law requires that a physician certify in all cases that the beneficiary is confined to his home (see § 240.1). An individual does not have to be bedridden to be considered as confined to his home. However, the condition of these patients should be such that there exists a normal inability to leave home and, consequently, leaving their homes would require a considerable and taxing effort. If the patient does in fact leave the home, the patient may nevertheless be considered homebound if the absences from the home are infrequent or for periods of relatively short duration. It is expected that in most instances absences from the home which occur will be for the purpose of receiving medical treatment. However, occasional absences from the home for nonmedical purposes, e.g., an occasional trip to the barber, a walk around the block or a drive, would not



necessitate a finding that the individual is not homebound so long as they are undertaken on an infrequent basis or are of relatively short duration and do not indicate that the patient has the capacity to obtain the health care provided outside rather than in the home.

Generally speaking, a beneficiary will be considered to be homebound if he has a condition due to an illness or injury which restricts his ability to leave his place of residence except with the aid of supportive devices such as crutches, canes, wheelchairs, and walkers, the use of special transportation, or the assistance of another person or if he has a condition which is such that leaving his home is medically contraindicated. Some examples of homebound patients which are also illustrative of the factors to be taken into account in determining whether a homebound condition exists would be: (1) a beneficiary paralyzed from a stroke who is confined to a wheelchair or who requires the aid of crutches in order to walk; (2) a beneficiary who is blind or senile and, therefore, requires the assistance of another person in leaving his place of residence; (3) a beneficiary who has lost the use of his upper extremities and, therefore, is unable to open doors, use handrails on stairways, etc., and, therefore, requires the assistance of another individual in leaving his place of residence; (4) a patient who has just returned from a hospital stay involving surgery who may be suffering from resultant weakness and pain and, therefore, his actions may be restricted by his physician to certain specified and limited activities such as getting out of bed only for a specified period of time, walking stairs only once a day, etc.; and (5) a patient with arteriosclerotic heart disease of such severity that he must avoid all stress and physical activity.

The aged person who does not often travel from his home because of feebleness and insecurity brought on by advanced age would not be considered confined to his home for purposes of receiving home health services unless he meets one of the above conditions. A patient who requires speech therapy but does not require physical therapy or nursing services must also meet one of the above conditions in order to be considered as confined to his home. Thus, a person who has undergone a laryngectomy yet is recovered to the point of being able to get about normally without undue effort would not be considered as confined to his home.

Although a patient must be confined to his home to be eligible for covered home health services, some services cannot be provided at the patient's residence because equipment is required which cannot be made available there. If the services required by an individual involve the use of such equipment, the home health agency may make arrangements with a hospital, extended care facility, or a rehabilitation center to provide these services on an outpatient basis



(see §§ 200.2 and 205.7). However, even in these situations, for the services to be covered as home health services the patient must be considered as confined to his home; and to receive such outpatient services it may be expected that a homebound patient will generally require the use of supportive devices, special transportation, or the assistance of another person to travel to the appropriate facility.

If for any reason a question is raised as to whether an individual is confined to his home, the agency will be requested to furnish the intermediary with the information necessary to establish that the beneficiary is homebound as defined above.

**208.5 Patient's Place of Residence.**—A patient's residence is wherever he makes his home. This may be his own dwelling, an apartment, a relative's home, a home for the aged, or some other type of institution. However, an institution may not be considered a patient's residence if it:

(a) Meets at least the basic requirement in the definition of a hospital (§ 112.1), i.e., it is primarily engaged in providing by or under the supervision of physicians, to inpatients, diagnostic and therapeutic services for medical diagnosis, treatment, and care of injured, disabled, or sick persons, or rehabilitation services for the rehabilitation of injured, disabled, or sick persons, or

(b) Meets at least the basic requirement in the definition of an extended care facility (§ 112.2), i.e., it is primarily engaged in providing to inpatients skilled nursing care and related services for patients who require medical or nursing care, or rehabilitation services for the rehabilitation of injured, disabled, or sick persons. If a patient is transferred from a participating extended care facility to a nonparticipating part of the facility which he uses as his home, the part will not be considered the patient's residence if it meets this requirement.

Thus, if an individual is a patient in an institution or distinct part of an institution which provides the services described in (a) or (b) above, he is not entitled to have payment made for home health services under either Part A or Part B since such an institution may not be considered his residence.

When a patient remains in a participating extended care facility following his discharge from active care, the facility may not be considered his residence for purposes of home health coverage.

210. SPECIAL CONDITIONS FOR COVERAGE OF HOME HEALTH SERVICES UNDER HOSPITAL INSURANCE (PART A)

In addition to the conditions listed in § 208, the following conditions must be met for coverage under hospital insurance.

210.1 Effect of Spell of Illness on Coverage.--Hospital insurance coverage extends only to home health visits (100 or less) furnished after the beginning of one spell of illness and before the beginning of the next.

The controlling event is the **beginning** of the spell of illness. Thus, the spell of illness requirement is satisfied if, when the home health services are furnished, the patient is either in a spell of illness, or has ended a spell of illness and not begun a new one. A series of visits ends with the beginning of a new spell of illness. (See § 112.3 for the definition of spell of illness and the examples in § 210.2 for the interrelationship of the spell of illness and the prior stay requirements.)

210.2 Prior Inpatient Stay.--In addition to the spell of illness requirement, the law further specifies that a patient is entitled to these home health visits under hospital insurance in the year following his most recent discharge from a covered stay of any duration in an extended care facility or from a stay of at least 3 consecutive days in:

1. a participating hospital, psychiatric hospital or tuberculosis hospital; or
2. a participating distinct part of a psychiatric or tuberculosis hospital; or
3. a nonparticipating hospital, psychiatric hospital, or tuberculosis hospital which meets at least the following requirements:
  - A. provides 24-hour nursing service rendered or supervised by a registered professional nurse and has a licensed practical nurse or registered professional nurse on duty at all times (§ 112.1E); and
  - B. where licensing of hospitals is provided for under State or local law, is licensed or approved by the State or local licensing agency as meeting the standards established for such licensing (§ 112.1G); and
  - C. is primarily engaged in providing to inpatients, by or under the supervision of doctors of medicine or osteopathy:

(1) diagnostic and therapeutic services for medical diagnosis, treatment and care of injured, disabled, or sick persons (§ 112.1A.1), or

(2) rehabilitation services for the rehabilitation of injured, disabled, or sick persons (§ 112.1A.2); and

D. is not primarily engaged in providing to inpatients skilled nursing care and related services for patients who require medical or nursing care. (See definition of an extended care facility in § 112.2.)

Nonparticipating psychiatric and tuberculosis hospitals need not meet the special requirements applicable to such hospitals to satisfy the prior stay requirements. Federal hospitals need not be licensed under State or local licensing laws to meet the prior stay hospital definition.

**NOTE:** Where the coverage of Part A home health services is dependent upon a nonparticipating hospital, psychiatric hospital, or tuberculosis hospital stay from which a patient was discharged **prior to January 1, 1968**, the following applies: the hospital must meet at least the conditions of participation for hospitals described in § 112.1 except requirements F, H, and I (the special requirements for tuberculosis and psychiatric hospitals need not be met).





In determining whether the 3-day period of hospitalization has been met, the day of admission, **but not the day of discharge**, is counted as a hospital inpatient day.

The discharge from the hospital which is required to qualify home health services for payment under hospital insurance must have occurred after June 30, 1966, and in a month in which the patient has attained age 65. Since the extended care facility discharge must be from a covered stay, it must have occurred after December 31, 1966. There must be an actual discharge of the patient from the hospital or extended care facility to his residence. See § 208.5 for conditions under which an institution may not be considered the patient's residence.

**Note:** Ordinarily the spell of illness and prior inpatient stay requirements will be met by the same 3-day stay in a participating hospital. However, there are special situations where multiple inpatient stays combine to satisfy both requirements.

**Example 1:** A covered 1-day hospital stay began a spell of illness but did not satisfy the prior stay requirement. A subsequent noncovered stay of at least 3 days' duration in a nonparticipating hospital described above could satisfy the prior inpatient stay requirement even though it would not start a spell of illness. The 3-day stay may occur, for example, within 60 days after the 1-day hospital stay, i.e., during the spell of illness, or more than 60 days after the 1-day hospital stay, i.e., after the spell of illness ended.

**Example 2:** A noncovered 3-day hospital stay in a nonparticipating hospital described above satisfies the prior stay requirement. A subsequent 1-day stay in a participating hospital starts the spell of illness.

See § 210.3 for time limit on plan establishment following discharge from prior stay.

The following are examples of situations where a single inpatient stay satisfies both requirements.

**Example 3:** A noncovered 3-day hospital stay in a nonparticipating hospital described above, is followed within 14 days by a 1-day covered extended

care facility stay. In this case, the 3-day hospital stay satisfies the prior stay requirement for coverage of the ECF stay (§ 110.3). The 1-day ECF stay begins the spell of illness and satisfies the prior stay requirement for subsequent home health services.

**Example 4:** A noncovered 3-day stay in a qualified but nonparticipating hospital (§ 112.3) satisfies both the spell of illness and prior stay requirements.

See additional examples in § 215.3.

**210.3 Fourteen-Day Limit on Plan Establishment.**—The plan for home health services (§ 208.3) must be established within 14 days after the patient's discharge from the qualifying prior inpatient stay. In determining the 14-day period, the day of discharge is **not** counted in the 14 days. For example, a patient's plan is established within 14 days if he was discharged from a hospital on August 1 and his plan was established on August 15.

In some cases services are furnished after discharge from the hospital or extended care facility and before the plan has been reduced to writing. Payment under Part A may be made for such services if authorized by a physician, provided the plan is reduced to writing within 14 days of the patient's discharge.

**210.4 Related Illness or Impairment.**—In order for home health services to be covered under hospital insurance, a doctor must certify that the patient needs intermittent nursing care or physical or speech therapy for any condition for which he was receiving inpatient hospital or extended care services.

**210.5 Transfer of Patient.**—If it becomes necessary for the patient to transfer to a different physician or home health agency (in a different locality) after the timely establishment of the required physician's plan, the original plan may be continued in the new locality if:

A. There is a referral by the patient's physician in the old locality of both the patient and the plan to a physician in the new locality.

B. The patient's physician in the new locality accepts the original plan of treatment and assumes the responsibility of conducting the required periodic reviews of the plan. The plan could be modified from time to time as determined necessary by the patient's physician in the new locality.

C. A participating home health agency in the new locality accepts the patient.

The number of posthospital home health visits already used in the old locality in the (applicable) year

would be taken into account in determining when the limit of 100 visits under the hospital plan is reached.

**Example:** A health insurance beneficiary has received 40 home health visits under Part A when it is decided that his overall recovery would be hastened if he moved to a relative's home in a city 100 miles away. However, the physician who established and is reviewing his home health plan recommends that the physical therapy treatments he has been receiving be continued. A physician in the distant city concurs and agrees to take responsibility for continuance of the plan. When the patient moves, the plan is submitted to a home health agency in that city and services continue as before. The patient is entitled to the remaining 60 home health visits in the applicable year under Part A at his new residence.

## **212. SPECIAL CONDITIONS FOR COVERAGE OF HOME HEALTH SERVICES UNDER SUPPLEMENTARY MEDICAL INSURANCE (PART B)**

**212.1 Non-Eligibility Under Hospital Insurance.**—For home health services to be covered under supplementary medical insurance, the patient must be currently enrolled in the medical insurance plan and where the home health services to be provided are covered under hospital insurance, not be eligible to receive such services under hospital insurance. Where a patient is eligible for home health services which are covered under both programs, the services are chargeable under hospital insurance. When the benefits payable under hospital insurance are exhausted, he may then utilize the benefits available under the supplementary medical insurance program. A plan covering services under the medical insurance program must be established by the physician, and must be reduced to writing before the agency bills for the services.

Prior inpatient care in a hospital or extended care facility is **not** required for coverage of home health services under the supplementary medical insurance plan.

**212.2 Change to Medical Insurance Home Health Services on Change of Residence.**—A patient who changes residence before exhausting his 100 home health visits under hospital insurance can receive further home health services **only** under the medical insurance program if there is no further eligibility for home health services under the hospital insurance plan. This might occur, for example, in the following situations:

A. The physician in the old locality terminates the posthospital home health plan, or

B. There is no physician in the new locality who agrees to accept both the patient and the plan, e.g., the new physician wants to establish an entirely new plan.

For coverage under medical insurance in these circumstances, the new physician must establish a new plan.

See § 210.5 for conditions under which home health services under hospital insurance may continue in the new locality.

## **215. DURATION OF HOME HEALTH SERVICES**

**215.1 Duration of Home Health Services Under Hospital Insurance.**—Under hospital insurance the patient is entitled to up to 100 visits in the 1-year period after the **most recent discharge** from a qualifying inpatient stay (§ 210.2) and before a new spell of illness begins (§ 210.1).

If before a series of home health visits is completed, a patient receives inpatient services which start a new spell of illness, the series of visits is terminated. Both the "prior inpatient stay" (§ 210.2) and "timely establishment of plan" (§ 210.3) requirements must be met in the new spell of illness to provide coverage for a new series of home health visits.

If, during the same spell of illness, the home health patient returns to a hospital or extended care facility for a stay which meets the prior-stay requirement, a new 1-year period for his Part A visits is established dating from his latest discharge. The total number of visits available before the next spell of illness begins remains unchanged.

In rare cases a home health patient may return to a hospital for a stay which satisfies the prior-stay requirement but does not begin a new spell of illness, i.e., a 3-day noncovered stay in a nonparticipating hospital which meets all the conditions of participation except for the utilization review and health and safety requirements (see § 112.1). In this situation a new 1-year period begins with the discharge and the number of visits remains unchanged.

The end of the year for hospital insurance purposes is determined as follows:

Count 365 days (366 when February 29 is included) beginning with the later of the following:

a. The date of discharge after June 30, 1966, from a 3-day stay in any hospital, or



b. The date of discharge after December 31, 1966, from an extended care facility stay for which post-hospital extended care benefits were payable on the patient's behalf.

**215.2 Duration of Home Health Services Under Supplementary Medical Insurance.**—Under supplementary medical insurance a patient is entitled to 100 visits in a calendar year. Entitlement to visits under supplementary medical insurance is related to the calendar year and is unaffected by the patient's spell(s) of illness. If entitled to services under both hospital insurance and supplementary medical insurance, the visits must first be charged against the hospital insurance.

The end of the year under medical insurance is December 31.

**215.3 Examples of Duration of Services Under Hospital and Medical Insurance.**

**Example 1:** Jones is hospitalized on February 10 and discharged on March 15, 1967; he has no other hospital or extended care facility stay in 1967 or 1968. He has 100 home health visits beginning the latter part of March and ending on February 20, 1968. All 100 visits are paid for under hospital insurance since the 1-year period runs from March 15, 1967, the date of the hospital discharge, to March 14, 1968. Although Jones' spell of illness ended on May 13, 1967, the end of the 60-day period beginning with the day of the hospital discharge, home health eligibility was unaffected since a new spell of illness did not begin subsequently.

**Example 2:** Robinson was an inpatient in a hospital four times during the same spell of illness, i.e., there was no period of 60 consecutive days during which he was not hospitalized. He was discharged from the hospital, which meets the requirements to qualify subsequent home health services for payment under hospital insurance, on March 15, 1967, May 13, 1967, July 12, 1967, and September 9, 1967. Each hospital stay was for at least 3 consecutive days except the last one. He had home health visits beginning with May 23, 1967, based on a plan established after his hospital discharge of May 13. The 1-year period for home health services under hospital insurance began May 13, 1967, the date of his most recent discharge (in relation to the first home health visit in the spell of illness) from a hospital after a stay of 3 days; it can end no later than July 12, 1968, 1 year after the latest discharge from a hospital stay of at least 3 con-

secutive days. Thus, in some situations, the "1-year period" during which an individual may have up to 100 home health visits may in fact exceed a year overall.

**Example 3:** Smith is hospitalized on February 10 and discharged on March 15. He reenters the hospital on July 4. He had 30 home health visits between March 15 and July 4. Since he had been out of the hospital for more than 60 days after his discharge on March 15, a new spell of illness began on July 4, when he reentered the hospital. Therefore, he is not entitled to any additional home health visits under hospital insurance based on his February–March hospital stay. However, an additional 100 home health visits under hospital insurance may begin based on his hospitalization beginning July 4, if he is confined for at least 3 days. If it is for less than 3 days, he will not qualify for home health visits under hospital insurance in the new spell of illness. However, if he is enrolled in the supplementary medical insurance program he is entitled to an additional 100 visits under Part B through December 31, subject to the deductible provisions.

**Example 4:** Brown is discharged from a hospital on February 15, 1967, after a 3-day stay. He begins receiving home health visits on February 18, 1967. He has until February 14, 1968, to use his 100 visits under hospital insurance. In July, however, he receives his 100th visit, exhausting the number of visits to which he is entitled under hospital insurance. Coverage of his home health visits may continue unbroken, if he is enrolled under supplementary medical insurance. In that event, he may receive an additional 100 visits under medical insurance through December. In January 1968, he becomes entitled to an additional 100 visits under supplementary medical insurance for the calendar year of 1968.

**218. COUNTING VISITS UNDER THE HOSPITAL AND MEDICAL PLANS**

The number of visits are counted in the same manner under both the hospital plan and medical plan.

**218.1 Visit Defined.**—A visit is a personal contact in the place of residence of a patient made for the purpose of providing a covered service by a health worker on the staff of the home health agency or by others under contract or arrangement with the home health agency; or a visit by a patient on an outpatient basis to a hospital, extended care facility, or rehabilitation

(Continued on page 19)





center, or outpatient department affiliated with a medical school when arrangements have been made by the home health agency for one or more of the covered services. (See § 200.)

**218.2 Counting Visits.**—If a visit is made simultaneously by two or more persons from the home health agency to provide a **single** service, for which one person supervises or instructs the other, it is counted as **one visit**. (See example 1.) If **one** person visits the patient's home more than once during a day to provide services, **each** visit is recorded as a separate visit (see example 2). If a visit is made by two or more persons from the home health agency for the purpose of providing separate and distinct types of services, **each** is recorded—i.e., **two or more visits** (see example 3). If the patient is taken elsewhere for the service because the service could not be furnished in his residence, **one visit** is counted **for each service** he receives (see example 4).

**Example 1.** If an occupational therapist and an occupational therapy assistant visit the patient together to provide therapy and the therapist is there to supervise the assistant, **one** visit is counted.

**Example 2.** If a nurse visits the patient in the morning to dress a wound and later must return to replace a catheter, **two** visits are counted.

**Example 3.** If the therapist visits the patient for treatment in the morning and the patient is later visited by the assistant for additional treatment, **two** visits are counted.

**Example 4.** If an individual is taken to a hospital to receive outpatient therapy that could not be furnished in his own home (e.g., hydrotherapy) and, while at the hospital receives speech therapy and other services, **two or more** visits would be charged.

**Example 5.** Many home health agencies provide home health aide services on an hourly basis (ranging from 1 to 8 hours a day). However, in order to allocate visits properly against a patient's maximum allowable visits, home health aide services are to be counted in terms of visits. Thus, regardless of the number of continuous hours a home health aide spends in a patient's home on any given day, one "visit" is counted for each such day. If, in a rare situation, a home health aide visits a patient for an hour or two in the morning, and again for an hour or two in the afternoon, **two** visits are counted.

Under both hospital insurance and supplementary medical insurance, visits count toward the 100-visit maximums only if payment was made for the visits by the program or, if payment would be made if requested by the patient, and the certification requirements (see §§ 240ff.) were met. Visits by personnel other than those providing covered services are not counted. Salaries of personnel employed by the agency to assist in overall operation of the program (e.g., a nutritionist)

may be taken into consideration in computing overhead costs of the agency when claiming reimbursement.

**Important item to remember about visits under supplementary medical insurance:** visits provided a patient during the period in which he is incurring sufficient expenses to satisfy the deductible **will count** toward the 100-visit maximum, even though reimbursement is not possible because the \$50 deductible has not been satisfied.

## 220. DEDUCTIBLE AND COINSURANCE UNDER SUPPLEMENTARY MEDICAL INSURANCE

**Note:** If the patient is receiving home health services under the **hospital insurance program**, he does not need to meet any deductible or coinsurance requirements. The home health agency will receive payment under the program for covered services based on the determined reasonable costs.

**220.1 Deductible.**—Where the patient is receiving services under the supplementary medical insurance program, a \$50 deductible requirement must first be met. Only expenses incurred by the use of covered services under supplementary medical insurance can be used to satisfy the deductible. **Exception:** The \$20 deductible applicable to each outpatient diagnostic study under hospital insurance may be used to help satisfy the \$50 deductible under supplementary medical insurance.

Expenses incurred in the last 3 months of the year which were applied toward the deductible in that year may also be applied toward the deductible in the following year. If the patient has already satisfied the deductible in the calendar year, this will be indicated on the Notice of Medical Insurance Utilization he receives from the Social Security Administration after a Part B home health services claim is processed, or on the Explanation of Benefits form he receives from the intermediary after other Part B claims are processed (see § 304). **The agency should attempt to ascertain whether or not the patient has satisfied the deductible before charging him for this amount.**

**220.2 Coinsurance.**—After sufficient expenses have been incurred to satisfy the deductible, the home health agency will be reimbursed by the program for 80 percent of the reasonable cost of covered services which it provided or for which it made arrangements. The patient is responsible for a coinsurance amount of 20 percent of the reasonable charges.

## 225. PROVIDER-BASED PHYSICIANS' SERVICES

The medical insurance program covers charges for physicians' services rendered to individual beneficiaries. The charges of provider-based physicians (e.g.,



those having a contractual relationship with a provider) for services directed to the medical care of the individual patient must be specially billed. Reimbursement is made on a reasonable charge basis by the supplementary medical insurance (Part B) intermediary. (The services of interns and residents-in-training are reimbursed on a reasonable cost basis by the hospital insurance intermediary.) Thus the charges for physicians' services rendered individual beneficiaries are allocated to the medical insurance program and distinguished from provider services payable under either the hospital or medical insurance plan. Claims for such physicians' services rendered in connection with home health agency services will be made by the physician, if he accepts assignment from the patient, or by the patient directly, on Form SSA-1490, Request for Payment.

Provider-based physicians often perform services other than those clearly directed to the medical care of individual patients. These may involve teaching and administrative services, and services that benefit the home health agency's patients as a group. Such physician services, not directly related to an individual patient, must be considered in computing reimbursable agency costs and, as such, will be reflected in amounts payable to the agency for services rendered program beneficiaries.

### **230. SPECIFIC EXCLUSIONS FROM COVERAGE AS HOME HEALTH SERVICES**

In addition to the general exclusions from coverage under health insurance listed in § 232, the following are also excluded from coverage as home health services:

- a. Services or items which would not be paid for if provided to an inpatient of a hospital, such as private duty nursing service, or items of comfort which are not necessary for treatment, e.g., television:
- b. Meals-on-wheels or similar food service arrangements.
- c. Domestic or housekeeping services which are unrelated to patient care.
- d. Transportation services, e.g., from place of residence to a facility to receive home health services on an outpatient basis.

### **232. GENERAL EXCLUSIONS**

No payment may be made under either the hospital insurance plan or supplementary medical insurance plan for the following items and services:

**232.1 Items and services which are not reasonable and necessary** for the diagnosis or treatment of illness or injury or to improve the functioning of a malformed body member.

**232.2 Items and Services for Which There Is No Legal Obligation to Pay.**—This exclusion does not apply if the patient has a legal obligation to pay,

or some other person or organization has a legal obligation to pay for or provide the items or services. Thus, for example, the exclusion does not apply to care provided or paid for by a prepayment plan.

Free services are excluded from coverage, e.g., free chest X-rays provided by health organizations. In applying this exclusion the determining factor is that there is no legal obligation to pay for the items or services, and not merely the fact that the patient is not charged because of other considerations. This exclusion, therefore, does not prohibit program payment for services rendered to members of religious orders who are not charged because of a vow of poverty or to indigents who are not charged because of their inability to pay.

Covered services furnished to residents of a **home for the aged** are not excluded where payment is sought from the resident for maintenance and health services to the extent of his ability to pay. This would be the case, for example, where at the time of admission the resident assigns to the home any assets or income he may have. However, where all services are furnished by the home on a purely charitable basis (i.e., no payment is accepted from residents regardless of their ability to pay), payment could not be made under the health insurance program for items and services furnished by the home. In this situation, however, payment could be made for services furnished by a source independent of the home if that source customarily charges for such services. Thus, payment could be made for services furnished by an independent hospital to which a resident of the home is sent.

Certain union homes accept no payment from residents regardless of their ability to pay. Payment may, nevertheless, be made for services provided by such homes where admission to the home and access to the services is a matter of right for union members who meet the necessary qualifications.

Payment may also be made for services to a patient whose need for services resulted from the act or negligence of another who is or may be legally liable for the patient's medical expenses. The existence of a third person's liability does not affect the patient's obligation to pay for the services he receives.

**232.3 Items and services which are paid for by a governmental entity** other than under the Social Security Act or under a health benefits or insurance plan for employees of the governmental entity. The Secretary of Health, Education, and Welfare may specify other exceptions to this exclusion. The Secretary has approved payment for items and services (otherwise covered) even though provided free:

1. If furnished in qualified State or local government-operated hospitals, including psychiatric and tuberculosis hospitals, where the hospital is a general or special hospital serving the general community;

2. If paid for by a State or local governmental entity and furnished an individual as a means of control-

ling infectious diseases or because of the individual's medical indigence. These services need not be furnished in a hospital.

**232.4 Items and services which are not provided within the United States** (except for emergency inpatient hospital services furnished outside the United States under certain conditions and payment on behalf of railroad beneficiaries for covered hospital insurance services furnished in Canadian hospitals). The United States includes the 50 States, the District of Columbia, the Commonwealth of Puerto Rico, the Virgin Islands, Guam, and American Samoa.

**232.5 Items and services which are required as a result of war**, or of an act of war, occurring after the effective date of the patient's current coverage.

**232.6 Personal Comfort Items.**—These are items which do not contribute meaningfully to the treatment of an illness or injury or the functioning of a malformed body member. Charges for special items requested by the patient such as radio, television, telephone, and air conditioner, and beauty and barber services are excluded from coverage. Items such as heat lamp treatments and massages are covered only when ordered by a physician.

**232.7 Routine physical checkups, eyeglasses or eye examinations for the purpose of prescribing, fitting, or changing eyeglasses, hearing aids or related examinations, or immunizations.** Routine physical checkups include (a) examinations performed without relationship to treatment or diagnosis of a specific illness, symptom, complaint, or injury, and (b) examinations required by third parties such as insurance companies, business establishments, or Government agencies.

The exclusions apply to eyeglasses or contact lenses, and eye examinations solely for the purpose of prescribing, fitting, or changing eyeglasses or contact lenses for refractive errors. The exclusions do not apply to examinations performed in conjunction with an eye disease such as glaucoma or cataracts, or to post-surgical eyeglasses which are customarily used during convalescence from eye surgery, or to prosthetic lenses required by the aphakic patient. In the last situation, the prosthetic lens is a replacement for an internal body organ—the lens of the eye.

Vaccinations or inoculations are excluded as "immunizations" unless they are directly related to the treatment of an injury or direct exposure such as anti-rabies treatment, tetanus antitoxin or booster vaccine, botulin antitoxin, antivenin sera, or immune globulin.

**232.8 Orthopedic Shoes or Other Supportive Devices for the Feet.**—The exclusion of orthopedic shoes does not apply to such a shoe if it is an integral part of a leg brace.

**232.9 Custodial Care.**—The custodial care exclusion precludes payment for patient care which primarily requires protective services rather than definitive medical and skilled nursing care.

**232.10 Cosmetic Surgery or Expenses Incurred in Connection With Such Surgery.**—Cosmetic surgery includes any surgical procedure directed at improving appearance, except when required for the prompt (as soon as medically feasible) repair of accidental injury or for the improvement of the functioning of a malformed body member. For example, this exclusion does not apply to surgery in connection with treatment of severe burns or repair of the face following a serious automobile accident or surgery for therapeutic purposes, which coincidentally also serves some cosmetic purpose.

**232.11 Charges Imposed by Immediate Relatives of the Patient or Members of His Household.**

**232.12 Items and services in connection with the care, treatment, filling, removal, or replacement of teeth** or structures directly supporting the teeth. Payment may be made, however, for (a) surgery related to the jaw or any structure contiguous to the jaw, or (b) the reduction of any fracture of the jaw or any facial bone, including dental splints or other appliances used for this purpose.

**232.13 Items and services to the extent that payment has been made, or can reasonably be expected to be made for items or services under a workmen's compensation law or plan of the United States or a State.** Payments made for items and services under the health insurance program are subject to repayment to the appropriate trust fund if notice or information is received that payment has been made for the items and services under a workmen's compensation plan (see §§ 250 ff.).

**232.14 Items and services which the provider is obligated by a law of or because of a contract with the Federal Government to render at public expense.**

**232.15 Items and services furnished by a Federal provider of services or other Federal agency** except (a) for emergency inpatient hospital services and emergency outpatient hospital diagnostic services furnished by a Federal hospital meeting certain requirements; or (b) when the Federal provider of services has been determined by the Secretary of Health, Education, and Welfare to be providing services to the public generally as a community institution or agency.

## **235. PATIENT'S REQUEST FOR PAYMENT**

Before payment can be made for home health services, a written request for payment signed by the patient or by another person qualified to do so on his



behalf must be filed. For convenience, the request for payment has been made a part of the billing form.

**235.1 Execution of the Request For Payment.**—If at all practicable, the request should be signed by the beneficiary.

In certain circumstances, it would be impracticable for an individual to sign the request for payment himself if, when he begins home health services, he is incompetent, or otherwise in such a condition that he should not be asked to transact any business. In this situation, his representative payee (i.e., a person designated by the Social Security Administration to receive monthly benefits on the patient's behalf), a relative, legal guardian, or a representative of an institution usually responsible for his care, or a representative of a government entity providing welfare assistance should, if present at the time services begin be asked and permitted to sign on his behalf.

When no request for payment is obtained at the time of start of services, the home health agency should attempt to obtain such a request later, if possible, from the patient or other person as described above who may be at the patient's home. If this is not practicable, when the agency would ordinarily submit its bill to the intermediary, an authorized official of the agency may sign the request on his behalf.

When someone other than the patient signs the request for payment, the signer will submit a brief statement explaining his relationship to the patient and the circumstances which made it impracticable for the patient to sign, and the agency will forward the statement with its billing. The intermediary will generally accept such a statement as representing the true facts of the case in the absence of evidence to the contrary.

The agency should not routinely sign the request on behalf of any patient. If experience reveals an unusual frequency of such agency-signed requests from a particular agency, the matter will be subject to review by the intermediary.

If a fully competent and capable patient refuses to sign the request for payment necessary for the agency to obtain reimbursement for the services it furnished, the agency may charge the patient or other person for covered services.

**235.2 Filing of the Request For Payment.**—The request for payment must be filed with the intermediary, or with the Social Security Administration where the agency deals directly with the Government. It is desirable to have the request signed at the start of care; the request must be filed prior to or in connection with the first billing for services. Home health services for the purposes of requests for payment will be considered continuous and will, except as indicated below, require only a single request for payment.

A subsequent signed request for payment will be required if:

a. There is an interruption of 60 days or more in home health visits furnished by the same agency or

b. There is a transfer of the patient's care from one home health agency to another.

## **240. CERTIFICATION AND RECERTIFICATION BY PHYSICIANS**

**240.1 Content of the Physician's Certification.**—Under both the hospital insurance and the supplementary medical insurance programs, no payment can be made for covered home health services unless a physician certifies that:

a. the home health services are or were required because the individual is or was confined to his home (except when receiving outpatient services);

b. the individual needed skilled nursing care on an intermittent basis or needed physical or speech therapy;

c. a plan for furnishing such services to the individual has been established and is periodically reviewed by a physician; and,

d. the services are or were furnished while the individual was under the care of a physician.

In addition, for services received under hospital insurance, the physician must also certify that services were needed to treat any of the conditions for which the beneficiary received inpatient hospital or post-hospital extended care services during the related hospital or extended care facility stay. Where services are provided under supplementary medical insurance, it is not necessary to relate the need for these services to a period of prior hospitalization or a stay in an extended care facility.

Since the certification is closely associated with the plan of treatment, the same physician who establishes the plan must also certify to the necessity for home health services. Certifications must be obtained at the time the plan of treatment is established or as soon thereafter as possible.

**240.2 Method and Disposition of Certifications.**—There is no requirement that the certification, or recertification discussed below, be entered on any specific form or handled in any specific way, as long as the intermediary can determine, where necessary, that the certification and recertification requirements are met. The certification by the physician will be retained by the home health agency, but the agency must certify on the billing form that the requisite certification and recertifications have been made by the physician and are on file in the agency when it forwards the request for reimbursement to the intermediary.

**240.3 Recertification.**—Under both the hospital insurance and supplementary medical insurance programs, when services are continued for a period of time, the physician must recertify at intervals of at least once every 2 months that there is a continuing need for services and should estimate how long services will be



needed. The recertification should be obtained at the time the plan of treatment is reviewed since the same interval (at least once every two months) is required for the review of the plan. Recertifications must be signed by the physician who reviews the plan of treatment. The form of the recertification and the manner of obtaining timely recertifications is up to the individual agency.

**240.4 Delayed Certification.**—The home health agency should obtain certifications and recertifications as promptly as possible. Payment will not be made unless the necessary certifications have been secured. In addition to complying with the usual content requirements, delayed certifications and recertifications must include an explanation for the delay and any other evidence the agency considers necessary in the case. The format of delayed certifications and recertifications and the method by which they are obtained, will be left to the agency.

## **245. REFUNDS**

In its participation agreement the home health agency agrees not to charge for items or services for which an individual is entitled to have payment made on his behalf. Thus, when the patient's eligibility is verified, the agency in order to have payment made under health insurance, is obliged to refund to the proper party any payments previously collected from beneficiaries, other insurance carriers, welfare, or others for covered services, except for deductibles, coinsurance amounts, and noncovered charges. When payment is made under medical insurance and the intermediary is aware that the beneficiary previously paid part of the reimbursable medical insurance expenses, the intermediary will deduct that part from the home health agency reimbursement and will refund the amount to the beneficiary.

## **250. WORKMEN'S COMPENSATION**

Payment is excluded for any items or services to the extent that payment has been made, or can reasonably be expected to be made under a workmen's compensation law or plan of the United States or a State. Health insurance payment for items or services is conditioned on reimbursement to the hospital or supplementary medical insurance trust fund when notice or other information is received that payment for them has been made under workmen's compensation.

**250.1 Effect of Workmen's Compensation Payments on Spell of Illness.**—An individual's spell of illness will begin with the first day he receives inpatient services from a qualified hospital or extended care facility even though workmen's compensation coverage, rather than the health insurance program, pays for these services, if he is entitled to hospital insurance benefits in that month.

**250.2 General Procedures in Workmen's Compensation Cases.**—When the home health agency is told that the patient's illness or injury is employment-related, this will be indicated on the billing form, and the employer's name and address given.

If the agency knows that a workmen's compensation payment has already been made for the current illness or injury (e.g., for prior hospitalization) it should furnish the intermediary whatever information is available with the start of care notice, since it is possible that subsequent care for the same injury or disease will also be compensable under workmen's compensation. If there is a possibility of workmen's compensation coverage for home health care, the agency should file its claim with the workmen's compensation carrier.

Even though workmen's compensation payment has been or probably will be made, the agency should submit its bill for covered health insurance services in the usual manner to the intermediary, or to the Social Security Administration if the agency is dealing directly with the Government.

a. If the agency has received a workmen's compensation payment, the intermediary will deduct the amount of that payment which was for covered health insurance services from the agency's bill. The agency will be notified by the intermediary of the extent to which its bill was covered by workmen's compensation. The patient will also be notified of this action.

b. If there is a reasonable likelihood that the agency will be paid by workmen's compensation for the patient's care the intermediary will notify the agency that health insurance payments are precluded because of the expected workmen's compensation payment. The patient is also notified of this decision.

If workmen's compensation does not pay or pays only in part for covered services, the agency may reopen the question of its bill with the intermediary.

c. If the intermediary determines that workmen's compensation payments cannot reasonably be expected, it will pay the agency for covered health insurance services on condition that the payment will be refunded if workmen's compensation later pays for the services. No conditional payment will be made unless workmen's compensation payment is doubtful (e.g., where the employer is contesting his liability under workmen's compensation or his liability for the expenses in question).

## **255. HOME HEALTH AGENCY PROTEST OF PAYMENT DETERMINATION**

The home health agency and its intermediary should attempt to resolve mutually any differences involving payment for services that arise from the application of the cost formula or the amount payable in a specific case. While no appeal is available for home health agencies or other providers from intermediary determinations involving payments, provider complaints and protests will be considered in Social Security Adminis-

tration review of the intermediary's application of the cost formula or its compliance with the other terms of its agreement with the Government.

## **257. BENEFICIARY PROTESTS AND APPEALS OF PAYMENT DETERMINATIONS**

**A. Hospital Insurance Program.**—An individual dissatisfied with any determination of the amount of benefits payable on his behalf under hospital insurance may have his claim reconsidered by the Social Security Administration. If he is not satisfied with the reconsideration determination and the amount in controversy is \$100 or more, he may request a hearing by the Social Security Administration. If the amount in controversy is \$1,000 or more and he is dissatisfied with the hearing decision, the individual may initiate action for Federal court review of the claim.

**B. Medical Insurance Program.**—An individual dissatisfied with denial of a request for payment of medical insurance benefits, or with the amount of medical insurance benefits paid, or with the promptness with which his request for payment is acted upon is entitled to an opportunity for a review by, and if still dissatis-

fied, to a fair hearing by the medical insurance intermediary. Since the home health agency is paid for the medical insurance services it furnishes by the same intermediary that makes hospital insurance payments to the home health agency, this intermediary is responsible for the review and hearing under medical insurance.

A patient dissatisfied with a payment for the services of a provider-based physician is entitled to a review by and, if still dissatisfied, to a fair hearing by the medical insurance intermediary to whom the bill for the physician's services was submitted for payment.

**C. Patient protests** concerning entitlement to health insurance benefits, or the denial, amount, or promptness of payment for items or services furnished by the home health agency under hospital or medical insurance should be handled, if simply amenable to explanation or correction, by the home health agency. If he is still dissatisfied, the patient should be referred to his social security district office. The district office can offer assistance to the beneficiary in determining his appeal rights and can answer specific questions about the appeal procedures. The district office can also assist the individual in completing the necessary forms for requesting reconsideration or hearing.



6-68

COVERAGE OF HOME HEALTH SERVICES

H221

Physical Therapy Services Furnished to Outpatients  
Covered Under Medical Insurance

**H221. OUTPATIENT PHYSICAL THERAPY SERVICES**

**Effective July 1, 1968**, coverage under Part B of physical therapy furnished on an outpatient basis is expanded by including such services furnished by or under arrangements made by a participating provider of services. Reimbursement for these outpatient physical therapy services will be made to the provider on a cost basis. The patient will be responsible only for the regular Part B deductible and coinsurance amounts (i.e., the annual \$50 deductible and 20 percent coinsurance).

For the purposes of this coverage, the term "provider of services" is extended to include approved clinics, rehabilitation agencies, and public health agencies as well as participating hospitals, extended care facilities, and home health agencies. To qualify as providers of services; clinics, rehabilitation agencies, and public health agencies will be required to meet certain conditions enumerated in the law and to enter into an agreement with the Secretary in which they agree not to charge any beneficiary for covered services for which the program will pay and to refund any erroneous charges made.

Payment may be made for outpatient physical therapy services furnished by a participating provider of services on or after July 1, 1968, only where a physician has certified that (1) such services are or were required because the individual needed physical therapy services on an outpatient basis, (2) a plan for furnishing such services has been established and is periodically reviewed by the physician, and (3) such services are or were furnished while the individual is or was under the care of a physician. In addition, the plan of treatment established by the physician must prescribe the type, amount, and duration of the physical therapy services to be furnished the individual.

This new provision represents an extension of coverage in that under prior law individuals who are not homebound and, therefore, are ineligible for home health benefits could receive outpatient physical therapy services only if provided as an incident to a physician's services (i.e., provided under his personal supervision with the charges for such services included in the physician's bill) or as a hospital service furnished incident to a physician's services.

Beginning with services furnished on or after July 1, 1968, such individuals may secure outpatient physical therapy from any participating provider of services without the requirement that the services be furnished incident to a physician's services. Such services may



be furnished an eligible outpatient in his home (including an institution serving as his place of residence such as an old-age home) or on the premises of the provider. Also, the inpatient of a nonparticipating institution which meets at least the basic definition of a hospital or extended care facility may receive outpatient physical therapy furnished by a participating provider of services.

Inpatients of participating hospitals or extended care facilities who have exhausted Part A benefits, or who are ineligible for Part A benefits, or who are in an institution which does not furnish physical therapy may receive physical therapy as an outpatient of another participating provider of service. For example, an inpatient of a participating extended care facility who has exhausted his benefit days may be furnished covered outpatient physical therapy by a participating hospital. While the inpatient of one provider may be considered the outpatient of another, it should be noted that since this is an outpatient benefit, a participating provider of services may not furnish "outpatient physical therapy" to its own inpatient.

This new provision will also permit a home health patient who runs out of visits to continue to receive covered physical therapy services from the home health agency (or other provider) providing he has Part B coverage. In addition, a beneficiary may receive home health services while he is simultaneously receiving Part B outpatient physical therapy services, and this is true without regard to whether the home health services are being provided under Part A or Part B and without regard to whether the outpatient physical therapy is being provided by the home health agency or some other provider. If, however, physical therapy is the service upon which the individual's entitlement to payment for home health services depends, he will lose his entitlement to home health services if he elects to receive physical therapy as a Part B medical and other health service; that is, outpatient physical therapy will not be simultaneously counted as a home health service and as a Part B medical and other health service. (No payment may be made for home health services unless a physician certifies that an individual needs either skilled nursing care on an intermittent basis, or physical or speech therapy. Assuming such a certification is made, the individual becomes entitled to all the home health services covered under the program which he requires.) If, on the other hand, the patient requires intermittent nursing care or speech therapy in addition to physical therapy, he may elect to have the physical therapy provided under Part B as a medical and other health service and thereby conserve his home health visits for the provision of other types of services he requires which may be reimbursed only as home health services.

Billing instructions for outpatient physical therapy services will be issued shortly.

Exclusion of Refractive Services

H232.7 Exclusion of Eye Care Services.--Effective January 1, 1968, the amendments expand the eye care exclusion in the present law by also excluding from coverage procedures performed to determine the refractive state of the eyes during the course of any eye examination. Thus, expenses for **all** eye refraction procedures, whether performed by an ophthalmologist (or any other physician) or by an optometrist and without regard to the reason for the performance of the refraction, are excluded from coverage under the program.

Exclusion of Foot Care**H233. EXCLUDED FOOT CARE SERVICES**

The amendments limit the scope of covered foot care services by excluding the following types of services under both Part A and Part B, effective January 1, 1968.

**A. Treatment of Flat Foot Conditions and Prescription of Supportive Devices Therefor.**--For the purposes of this exclusion, treatment of "flat foot conditions" means treatment of the local condition of flattened arches regardless of the underlying pathology causing it, except where such treatment is purely incidental to and an integral part of covered foot treatment (for example, treatment of a fracture). The term "treatment" encompasses all phases of services in connection with flat feet, including evaluations as well as any measures or devices designed either to correct the condition or to palliate pain and other symptoms associated with the condition.

**B. Treatment of Subluxations of the Foot.**--For the purposes of this exclusion, the term "subluxation" refers to structural misalignments of the feet (except fractures and complete dislocations) which do not require treatment by surgical methods, regardless of the underlying pathology. Excluded "treatment" of the above conditions includes evaluations as well as the nonsurgical measures, supplies, or appliances used to correct the condition or alleviate symptoms. The exclusion does not apply where such treatment is purely incidental to and an integral part of covered foot treatment (such as treatment of a fracture) or where performed as a part of postoperative care during the period of convalescence from covered foot surgery.

This exclusion does not apply to the ankle joint (talo-crural joint).

**C. Routine Foot Care.**--Routine foot care includes the cutting or removal of corns, warts, or calluses, the trimming of nails, and routine hygienic care. "Routine hygienic care" includes hygienic and preventive maintenance care of the feet, of the type which is ordinarily considered self-care, such as observation and cleansing of the feet, use of skin creams to maintain skin tone of both ambulatory and bedfast patients, nail care not involving surgery, prevention and reduction of corns, calluses and warts, and any services performed in the absence of localized illness, injury, or symptoms involving the foot.



The above types of "routine" care are excluded regardless of the reason for such care. Thus, the fact that a particular individual is unable to perform certain care for himself (for example, because of a physical disability or a predisposing systemic disease such as diabetes or peripheral vascular disease which makes preventive hygienic foot care particularly important) does not change the character of the services and make them "nonroutine." Hygienic and other care which is simply incident to and an integral part of active covered treatment of foot lesions, such as infections and diabetic ulcers, is not considered as "routine" care and hence is not excluded.

**H233.1 Application of Foot Care Exclusions to Provider Services.---**

Charges for provider services furnished in connection with non-covered foot care which are normally separately identified by the provider must be shown as noncovered charges. However, the provider need not identify services in connection with noncovered foot care where it is neither the normal practice to separately identify the services nor administratively feasible to establish a separate charge for such services, or where such services are performed only incidentally at the same time as and as a necessary integral part of a primary covered procedure.



### Chapter III

## START OF CARE PROCEDURES

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## Chapter III

### START OF CARE PROCEDURES

#### 300. SUMMARY OF START OF CARE PROCEDURES

The purpose of this section is to give a brief outline of routine handling of admissions. Detailed instructions on procedures as well as descriptions of special situations are given in subsequent sections.

The first step in preparing the start of care notice for home health services is to ask the patient for his health insurance card. **It is very important that the claim number on this card be accurately recorded on the start of care notice since the case cannot be processed if the number is missing or incorrect.**

If you cannot obtain the health insurance claim number from the patient, you should get in touch with the Social Security Administration district office for help in securing a claim number for the patient.

The second step is to record information about the patient's prior hospital or extended care facility stays, or any prior home health services furnished, and the date the present home health plan was established. This information will help the intermediary to determine the patient's eligibility. Your intermediary (or the Social Security Administration, if you are dealing directly with the Government) will make any necessary verification of prior stays.

The third step is to fill in the other items on the start of care notice, have the patient sign the form, and send the information to your intermediary, or the social security district office if you deal directly.

Your intermediary will check the Social Security Administration central record, verify a prior stay if necessary, then send you a reply which will show whether the patient is eligible under hospital or medical insurance, the number of visits remaining, and deductible status. With this information you will be able to prepare your billing form.

#### 302. HEALTH INSURANCE CARD

The Social Security Administration maintains in Baltimore, Maryland, the records of all persons entitled to health insurance. After entitlement is established

each beneficiary is issued a health insurance card by the central office of the Social Security Administration (or in some cases by the Railroad Retirement Board) for use in obtaining hospital insurance benefits, medical insurance benefits, or both. The health insurance claim number on the card is essential in locating the patient's record when a claim for benefit payment is made. **No start of care notice or billing form should be forwarded without the correct claim number.** Exhibit 1 of this chapter shows the health insurance cards and briefly explains the numbering system as an aid in recognizing valid numbers.

The home health agency should ask each patient who gives his age as 65 or older for his health insurance card to determine his health insurance entitlement status and obtain the correct health insurance claim number. If a patient is within 3 months of age 65 and has not yet applied for health insurance entitlement, it will be helpful if he, or someone on his behalf, is advised to contact the social security district office. The home health agency may wish to arrange with the district office to bring such cases routinely to the attention of the district office.

A health insurance card is acceptable without a signature. However, the patient should be asked to sign the card if he has not already done so.

#### 304. CERTIFICATE OF SOCIAL INSURANCE AWARD AND TEMPORARY NOTICE OF ELIGIBILITY

An individual who has not yet received his health insurance card may present one of the following to indicate his health insurance entitlement status.

a. **Certificate of Social Insurance Award.**—Health insurance beneficiaries receive a Certificate of Social Insurance Award (see § 399, Exhibit 5) showing the health insurance claim number, dates of entitlement to Part A and Part B, and containing the following statement:

"This notice may be used if medicare services are needed before you receive your health insurance card."

b. **Temporary Notice of Eligibility.**—When a person 65 years or older needs immediate medical serv-

ices, the social security district office may issue a Temporary Notice of Eligibility (see § 399, Exhibit 6) before a Certificate of Social Insurance Award or health insurance card is issued.

The patient's name and health insurance claim number shown on these notices should be entered on the start of care notice. The intermediary will use this information to check the Social Security Administration central record and to reply to the agency about the patient's eligibility and deductible status.

### **306. NOTICE OF HOSPITAL (OR MEDICAL) INSURANCE UTILIZATION OR EXPLANATION OF BENEFITS**

If the patient cannot furnish his health insurance card, he may have a health insurance utilization form which shows his claim number. Form SSA-1533, Your Record of Hospital Insurance Benefits Used Under Medicare (see Exhibit 2), is mailed to a beneficiary from the Social Security Administration in Baltimore shortly after **Part A** inpatient hospital, extended care, or **home health** benefits have been paid on his behalf. Form SSA-1533A, Notice of Medical Insurance Utilization (see Exhibit 3), is mailed to a beneficiary by SSA after payment of **Part B** home health benefits. An Explanation of Benefits is sent to a beneficiary by the Part B intermediary after payment of a supplementary medical insurance claim. The Part A intermediary sends the beneficiary a utilization notice after payment on his behalf for outpatient hospital services. These forms, if current, may indicate to the home health agency the patient's remaining eligibility under hospital or medical insurance, recent hospitalization, or deductible status under medical insurance. **However, a start of care notice must always be sent when home health services start regardless of the currency of any of these forms.**

### **310. CONTACTS WITH THE SSA DISTRICT OFFICE TO OBTAIN HEALTH INSURANCE CLAIM NUMBERS**

When a patient cannot furnish the health insurance claim number, it will be requested from the SSA district office. Ordinarily, the social security district office will have arranged with the home health agency for handling these requests. If it has not, the home health agency should get in touch with the nearest SSA district office to make such arrangements. Apart from assisting in determining correct claim numbers, the district office can help a beneficiary to replace a lost health insurance card.

### **312. INFORMATION REQUIRED BY SSA DISTRICT OFFICE**

If the patient's social security account number is available, the district office will usually require no additional information to locate the claim number or determine that the patient has not established health insurance entitlement.

If the patient has ever been employed or self-employed, or sought employment, or filed Federal Income Tax returns, he should have a social security card. This card contains his social security account number which consists of 9 digits, 000-00-0000, but does not have the letter prefix or suffix which distinguishes the health insurance claim number. (See Exhibit 1.)

A social security account number is **not** sufficient for processing a claim.

If the account number is not available, the following information should be furnished.

a. The patient's name and statement as to whether or not he ever applied for social security monthly benefits, railroad retirement benefits, or for hospital insurance benefits;

b. If the patient says he applied, the name of the person on whose social security account the application was based, e.g., his own account or the account of a husband or a wife;

c. The patient's father's full name, mother's maiden name, and the patient's date and place of birth;

d. Patient's address.

If the home health agency cannot give all the identifying information required from the beneficiary, it should furnish as much as it has to the SSA district office.

### **314. THE SSA DISTRICT OFFICE REPLY**

The SSA district office will furnish the health insurance claim number as soon as possible. If the claim number is not available, it will inform the home health agency of the action it is taking, i.e., that a claim number has been requested from SSA central records, that it is developing an application, or that an application is pending.

If an application for health insurance benefits is taken as a result of the request to the district office for a claim number or is pending when the home health agency requests a claim number, the district office will give the agency the claim number when processing is completed. The agency may then send the start of care notice information to the intermediary (or to the district office if the agency deals directly with SSA).



## 320. START OF CARE NOTICE

When a patient 65 years or older begins home health services, the home health agency will complete the start of care notice part (items 1-16) of Form SSA-1487, Home Health Agency Report And Billing Form (see Exhibit 4, § 399). When signed, this represents the patient's request for payment of benefits. See §§ 235 ff.

When these items are completed, furnish the start of care information to the intermediary (or to the appropriate Social Security Administration district office if the agency deals with SSA). This information may be forwarded by mail, messenger, or telephone depending on prior arrangements made with the intermediary or the SSA district office. The bottom two copies of Form SSA-1487 can be sent to the intermediary as the start of care notice if the arrangement so provides. If some other means of transmitting start of care information to the intermediary is used, these copies of the form may be discarded.

See § 325 for proper entries for items 1-16 of Form SSA-1487.

## 322. WHEN THE AGENCY SUBMITS A START OF CARE NOTICE

A start of care notice is required in the following situations:

a. The patient will receive home health services under Part A after a qualifying stay in a hospital or extended care facility.

b. The patient will receive initial home health services under Part B. This applies when services will be under Part B from the beginning.

c. The patient is discharged from a home health plan of treatment, and the physician later establishes a new plan for services, whether or not it differs from the prior plan.

d. The patient receives home health services from one agency and transfers to another agency.

e. The patient initially received Part B services, and later has a qualifying inpatient stay which entitles him to Part A visits.

f. A patient receiving Part A home health visits has a qualifying stay in a hospital or extended care facility which begins a new spell of illness and entitles him to a new series of 100 Part A visits.

g. The patient's home health visits are suspended for more than 60 days and are resumed after the 60th day. (Note: For the purpose of medicare reimbursement, the patient's home health plan is considered terminated if visits are not furnished for more than 60 days, see § 425.)

## 323. WHEN THE AGENCY NEED NOT SUBMIT A START OF CARE NOTICE

A start of care notice is not required in the following situations:

a. The same home health agency transfers services from Part A to Part B because either visits have been exhausted under Part A or a new spell of illness has begun.

b. Services furnished under Part B extend from one calendar year into another.

c. The same home health agency resumes Part A or Part B home health visits after a temporary suspension for a period no longer than 60 days. (See § 425.)

d. The patient is receiving Part A home health visits, and is readmitted to a hospital or extended care facility in the same spell of illness, and visits continue after discharge from the institution.

## 325. HOW THE AGENCY COMPLETES A START OF CARE NOTICE (FORM SSA-1487)

All entries should be typed or printed clearly. Show month, date, and year in six digit numbers, e.g., 10/01/67.

*Item 1. Patient's Name.*—Enter the patient's name as it is shown on his health insurance card. Do not make any changes in the name (except to show the last name first). The SSA master computer record is kept under this name.

*Item 2. Health Insurance Claim Number.*—Enter the patient's health insurance claim number as shown on his health insurance card, Certificate of Award, Notice of Hospital or Medical Insurance Utilization, Temporary Notice of Eligibility, or as reported by the social security district office.

*Item 3. Patient's Address.*—Enter the patient's mailing address. If the address is an institution, enter the name of the institution. Note: An individual in an institution meeting the basic definition of a hospital or extended care facility cannot be considered to be in a place of residence for purposes of receiving covered home health services; see § 208.5.

*Item 4. Date of Birth.*—Enter the patient's date of birth. If the year of birth is unknown, make no entry. If the year is known but the month or day is unknown enter "00" for the missing item, e.g., 00/00/95.

While the date of birth is useful as identification and

should be shown when available, a start of care notice will be processed without the date of birth.

*Item 5. Sex.*—Enter “X” in the appropriate box.

*Items 6 and 7. Home Health Agency Identification.*—Enter the name and address of the agency and the agency’s health insurance provider number. This information may be preprinted on all copies of the agency’s supply of these forms.

*Item 8. Medical Record Number.*—Enter the patient’s medical record number if one is assigned by the agency, and it is needed for the purpose of associating files or for referral purposes.

*Item 9. Name and Address of Attending Physician.*—Enter the name of the attending physician. The name should be that of the physician who established the plan and will certify and recertify the medical necessity of the home health visits. Show the address only if your intermediary requires this information.

If the plan was set up by an outpatient clinic rather than by a private physician, enter that information. However, if it is known that only one physician or department of the clinic is involved, enter that information.

*Item 10. Date Care Started.*—Enter the date on which covered home health services actually began. (This cannot be earlier than the patient’s effective date of health insurance (Part A or Part B) entitlement.) This date will remain the same on subsequent bills even if (a) the patient transfers from one agency to another or (b) Part B visits will be made because either Part A visits are exhausted or a new spell of illness has begun.

If reimbursable services not charged as visits, e.g., medical supplies and appliances, are furnished before the first visit, Item 10 will be the date these services were first furnished.

*Item 11. Name and Address of Institution, Etc.*—If home health visits follow a qualifying inpatient stay,

enter the name and address of the hospital or extended care facility.

To qualify for visits under Part A—

a. A spell of illness must have begun (see §§ 112.3 and 210.1).

b. Visits must follow an inpatient hospital stay of at least 3 consecutive days or a covered stay of any duration in an extended care facility (see § 210.2).

c. No more than 14 days can pass between discharge from a qualifying stay in a hospital or extended care facility and the establishment of a plan (see § 210.3). However, a plan may be established before the patient is discharged.

In the unusual situation where inpatient stays in two different institutions qualify the patient for Part A visits, i.e., one starts a spell of illness and the other satisfies the prior stay requirement (see § 210.2), the names and addresses of both institutions should be shown in Item 11. If verified, the dates of the stay which began the spell of illness should also be shown in Item 11. See example below.

*Item 12. Verified Dates of Stay in Item 11.*—Enter the verified dates of the inpatient stay qualifying visits under Part A only when the dates are taken from the official referral sheet of the hospital or extended care facility. Verified dates entered on the initial bill, need not be repeated on subsequent bills.

Home health agencies may wish to make arrangements with other providers to include the verified dates of stay as part of the normal information furnished when home health visits will follow a qualifying stay.

If inpatient stays in two different institutions qualify the patient for Part A visits (see Item 11 above), the dates of stay that began the spell of illness should be entered in Item 11 and the dates of the qualifying prior stay should be entered in Item 12. See example below.



**Item 13. Date Home Health Plan Established.**—Show the date on which the patient's attending physician established the plan for home health services.

The date shown in Item 13 can be **no later** than the "Date Care Started" shown in Item 10.

Home health services may be authorized verbally by a physician. In this case, the date of verbal authorization will be shown. However, the agency must make sure the plan is reduced to writing within 14 days of discharge from the qualifying stay in a hospital or extended care facility, if payments are to be made under Part A. If the services are payable only under Part B, the plan must be reduced to writing before a bill is submitted to the intermediary.

**Item 14. Payment Source, etc.**—Check the appropriate box to indicate how charges not reimbursed by health insurance will be paid.

If Item E (Public Agency) is checked, enter the name and address of the public agency and, if it is available, the case number assigned to the patient by the public agency. This information will be useful to the intermediary if it needs to forward a copy of the billing form to the public agency.

Item 14 may be completed on the first billing instead of on the start of care notice if the agency prefers. If the agency will not bill anyone for expenses not reimbursable under medicare, the item should not be completed.

**Items 15 and 16. Patient's Certification and Payment Request, and Diagnosis.**—These two items should be completed but if diagnosis is not readily available do not delay sending the start of care notice. For details on completion of these two items see § 405.

### 330. CONTENTS OF INTERMEDIARY REPLY TO START OF CARE NOTICE

The reply to the start of care notice will be furnished by the intermediary to the agency according to prior arrangements. (If the agency deals directly with the Social Security Administration, it will receive a form reply to the start of care notice from the Bureau of Health Insurance, Direct Reimbursement.) The contents of the reply will be based on the intermediary's query of the SSA central record for eligibility information, and any necessary investigation of prior inpatient hospital or extended care facility stays or home health services.

The "Report of Eligibility" part of the home health agency report and billing form (see Exhibit 4) may be

used as a reply to the start of care notice, where it is received by the intermediary as part of the start of care notice from the agency. Whether the reply will be given by telephone, mail, or wire to the agency, it will contain eligibility information similar to the content of the "Report of Eligibility." An explanation of the eligibility information in the "Report of Eligibility" is outlined below:

**A. Effective Date—Hospital Insurance.**—The month, day, and year of the patient's entitlement to hospital insurance benefits (Part A) will be shown. If not entitled, the entry will so indicate.

**B. Effective Date—Medical Insurance.**—This will show the month, day, and year of the patient's entitlement to medical insurance (Part B). The entry will so indicate if the patient is not entitled to Part B benefits.

**C. Date of Start of Care.**—This date will be the one furnished by the agency in the start of care notice.

**D. Hospital Insurance Visits Available.**—This will show the remaining number of visits which may be reimbursed under Part A, based on the SSA central record and the information available to the intermediary.

**E. Supplementary Medical Insurance Visits Available.**—This will show the potential remaining home health visits which may be reimbursed under Part B.

**F. Last Discharge Date.**—The last discharge from an inpatient hospital or covered extended care facility stay will be shown.

**G. Medical Plan Deductible.**—This will show if the \$50 deductible is "met" or "not met," but if not met will not indicate how much remains to be met. If the reply shows "not met," the home health agency should ask the patient whether he has had other expenses that have been or could be applied toward the deductible (see § 220.1). If the reply shows "not met" the intermediary must requery the SSA central record when it receives a Part B bill for payment from the home health agency in order to learn the amount of the deductible remaining to be met.

**H. Outpatient Psychiatric Expense.**—Whether the \$500 limitation has been "met" or "not met" will be shown in this item. If not met, the amount remaining to be met will not be shown. This item is informational only. The limitation applies only to expenses incurred for physicians' services.

**I. Remarks.**—Any necessary explanation of eligibility information will be shown. This will include



corrections in the name or health insurance claim number reported by the agency. When changes of this sort are reported, the name and claim number information on the billing form should be changed to reflect the correct name or health insurance claim number.

If the name and claim number information were not matched, the intermediary will request the home health agency to check its record, or to contact the patient or the nearest district office to obtain a valid claim number.

The agency may also be requested to verify reports of death shown in the patient's SSA central record.

**J. Open Item.**—The information in this block will be completed by the intermediary when verifying reports of open items (open items are admissions or care-starts which are recorded in SSA central records, but are not yet closed out by the processing of a bill).

Where there is an open item reported from SSA central records to the intermediary or the Bureau of Health Insurance, Direct Reimbursement, either the intermediary or Direct Reimbursement will contact the "open item" provider to verify the stay, the date of the prior discharge, and the status of the bill. The intermediary or the Bureau of Health Insurance, Direct Reimbursement, will use this information to determine whether Part A benefits are payable and to compute the number of visits remaining under Part A and Part B.

### **340. RETROACTIVE ENTITLEMENT**

When an application for social security benefits is filed by a person over 65 years of age, he may inform the social security office that he received home health services in the retroactive period of up to 12 months for which he may be entitled to benefits. Payment for the home health services (Part A only) received in this period is possible (see §120). The social security office will tell the individual to get in touch with the agency. In these cases, follow the start of care procedure to obtain a report of eligibility from your intermediary before billing. If the patient had paid the agency, the agency should refund the appropriate amount.

### **399. EXHIBITS**

**Exhibit 1.** Health Insurance Cards and Claim Numbers.

**Exhibit 2.** Your Record of Hospital Insurance Benefits Used Under Medicare (Form SSA-1533).

**Exhibit 3.** Notice of Medical Insurance Utilization (Form SSA-1533A).

**Exhibit 4.** Home Health Agency Report and Billing (Admission Copy) (Form SSA-1487).

**Exhibit 5.** Certificate of Social Insurance Award.

**Exhibit 6.** Temporary Notice of Eligibility.

## HEALTH INSURANCE CARDS

Health Insurance	
SOCIAL SECURITY ACT	
NAME OF BENEFICIARY <b>JANE Q. DOE</b>	
CLAIM NUMBER <b>000-00-0000B</b>	SEX <b>FEMALE</b>
IS ENTITLED TO EFFECTIVE DATE	
HOSPITAL INSURANCE	<b>7-1-66</b>
MEDICAL INSURANCE	<b>7-1-66</b>
SIGN HERE <input type="checkbox"/>	

Front

Health Insurance	
RAILROAD RETIREMENT BOARD	
NAME OF BENEFICIARY <b>JOHN C. DOE</b>	
CLAIM NUMBER <b>A-000-00-0000</b>	SEX <b>MALE</b>
IS ENTITLED TO EFFECTIVE DATE	
HOSPITAL INSURANCE	<b>7-1-66</b>
MEDICAL INSURANCE	<b>7-1-66</b>
SIGN HERE <input type="checkbox"/>	

Front

1. Carry your card with you when you are away from home.
2. Let your hospital or doctor see your card when you require hospital, medical or health services under "Medicare."
3. Get in touch with your social security office if you have questions about your rights under "Medicare."
4. Your card is good wherever you live in the United States.

WARNING: Issued for the sole use of the holder designated hereon. Intentional misuse of this card is unlawful and will make the offender liable to penalty.

PROPERTY OF UNITED STATES GOVERNMENT.  
IF FOUND DROP IN NEAREST U.S. MAIL BOX.

Return To: SOCIAL SECURITY ADMINISTRATION  
Baltimore, Maryland 21235

FORM SSA-1966 (7-66)

Back

1. Carry your card with you when you are away from home.
2. Let your hospital or doctor see your card when you require hospital, medical or health services under "Medicare."
3. Get in touch with your Railroad Retirement Board office if you have questions about your rights under "Medicare."
4. Your card is good wherever you live in the United States. For benefits in Canada, write to the Railroad Retirement Board.

WARNING: Issued for the sole use of the holder designated hereon. Intentional misuse of this card is unlawful and will make the offender liable to penalty.

PROPERTY OF UNITED STATES GOVERNMENT.

IF FOUND DROP IN NEAREST U.S. MAIL BOX.

Return to: RAILROAD RETIREMENT BOARD  
844 Rush Street, Chicago, Illinois 60611

Form G-43 (2-66)

Back

## HEALTH INSURANCE CLAIM NUMBERS

Most HI claim numbers are 9 digits with a letter or letter and numeral suffix; e.g., 000-00-0000B or B1. They may also be 6-or-9-digit numbers with lettered prefixes; e.g., A000000, A-000-00-0000; or WD-000000, WD-000-00-0000. Numbers with one or more letter prefixes identify Railroad Retirement Board annuitants.

Possible suffixes are:

A, B, B1, B2, B3, B4, B5, B6, or B9

C1, C2, C3, C4, C5, C6, C7, C8, or C9

D, D1, D2, D3, D4, D5, D6, or D7

E, E1, E2, or E3

F1, F2, F3, F4, F5, F6, F7, or F8

HB, HB1, HB2, HB3, HB4, HB5, HB6, or HB9

HC1, HC2, HC3, HC4, HC5, HC6, HC7, HC8, or HC9

J1, J2, J3, J4 (For subscripts "3" and "4" there can be no entitlement to hospital insurance benefits.)

K1, K2, K3, K4 (Supplementary medical insurance entitlement may exist for all J and K suffixes.)

M, M1, and T (Suffix letter "T" indicates entitlement to hospital or hospital and medical insurance; letters M and M1 indicate that the patient is eligible for supplementary medical insurance benefits but not for hospital insurance benefits.)

When the status of a beneficiary changes, it is possible for the suffix of his claim number to change.

EXHIBIT 2

Your Record of Hospital Insurance Benefits Used Under Medicare, SSA-1533



DEPARTMENT OF  
HEALTH, EDUCATION, AND WELFARE  
SOCIAL SECURITY ADMINISTRATION

**YOUR RECORD OF HOSPITAL INSURANCE  
BENEFITS USED UNDER MEDICARE**  
(THIS IS NOT A BILL)

DATE:

YOUR CLAIM NUMBER:

In any correspondence, please refer to this number.

Dear Beneficiary:

Recently, your Medicare Hospital Insurance helped pay for the services described below. We are pleased that your social security program was able to assist you.

**1. OUR RECORDS SHOW THAT YOU RECEIVED THESE SERVICES**

SERVICES WERE PROVIDED BY

TYPE OF SERVICES

WHEN

TO

Your Medicare Hospital Insurance has paid the cost of all COVERED SERVICES except:

For information about any services NOT COVERED by your Medicare Hospital Insurance, please see other side.

If you have any questions about this record, please get in touch with:

**2. OUR RECORDS NOW SHOW THESE BENEFIT TOTALS**

USED THIS TIME

TOTAL USED

AVAILABLE TO USE FOR  
THIS "SPELL OF ILLNESS"  
(See "D" on other side.)

INPATIENT HOSPITAL DAYS \_\_\_\_\_

EXTENDED CARE FACILITY DAYS \_\_\_\_\_

HOME HEALTH VISITS \_\_\_\_\_

If you again use services which are covered by your Medicare Hospital Insurance, please show this Record and your Health Insurance Card to the organization providing services.  
SEE OTHER SIDE FOR ADDITIONAL INFORMATION.

Sincerely yours,

*Robert M. Ball*

Robert M. Ball  
Commissioner of Social Security



## EXHIBIT 3

Notice of Medical Insurance Utilization, SSA-1533A

FORM SSA-1533A (5-66)



DEPARTMENT OF  
HEALTH, EDUCATION, AND WELFARE  
SOCIAL SECURITY ADMINISTRATION  
BALTIMORE, MARYLAND 21235

## NOTICE OF MEDICAL INSURANCE UTILIZATION

NAME AND ADDRESS OF THE BENEFICIARY  
OR REPRESENTATIVE OF THE BENEFICIARY

DATE:

HEALTH INSURANCE CLAIM NUMBER:

The bill for MEDICAL INSURANCE services described below was recently submitted under your health insurance claim number and recorded to your account.

TYPE OF SERVICES	DATES COVERED BY BILL		NUMBER OF HOME HEALTH VISITS INCLUDED
	FROM	TO	

Institution or agency  
furnishing services

Office which handled  
your claim

Each year, as soon as your covered medical expenses go over \$50, your MEDICAL INSURANCE will pay 80 percent of the reasonable costs or charges for all additional covered services for the rest of the year. The computation of MEDICAL INSURANCE benefits for this bill is shown below.

TOTAL COVERED CHARGES	AMOUNT TOWARD \$50 DEDUCTIBLE	20% PAYABLE BY BENEFICIARY	TOTAL PAYABLE BY BENEFICIARY

## STATUS OF MEDICAL INSURANCE RECORD

As of the date of this notice, the status of your MEDICAL INSURANCE record is as follows:

*Robert M. Ball*

Robert M. Ball  
Commissioner of Social Security

PLEASE READ THE OTHER SIDE OF THIS NOTICE FOR IMPORTANT INFORMATION.

## EXHIBIT 4

## Home Health Agency Report And Billing, SSA-1487 (Admission Copy)

DEPARTMENT OF HEALTH, EDUCATION, AND WELFARE SOCIAL SECURITY ADMINISTRATION		HOME HEALTH AGENCY REPORT AND BILLING		Form Approved. Budget Bureau No. 72-R736	
1. PATIENT'S LAST NAME		FIRST NAME		MI	2. HEALTH INSURANCE CLAIM NUMBER
3. PATIENT'S ADDRESS (Street number, City, State, Zip Code)				4. DATE OF BIRTH	
6. HOME HEALTH AGENCY NAME AND ADDRESS				5. SEX <input type="checkbox"/> M <input type="checkbox"/> F	
				9. NAME AND ADDRESS OF ATTENDING PHYSICIAN	
				8. MEDICAL RECORD NO.	
10. DATE CARE STARTED		11. NAME AND ADDRESS OF INSTITUTION, IF ANY, CARING FOR CONDI- TION LATER REQUIRING HOME HEALTH SERVICES		12. VERIFIED DATES OF STAY IN ITEM 11	
				FROM TO	
				13. DATE HOME HEALTH PLAN ESTABLISHED	
14. PAYMENT SOURCE FOR CHARGES TO PATIENT					
A. <input type="checkbox"/> SELF OR FAMILY C. <input type="checkbox"/> BLUE CROSS E. <input type="checkbox"/> PUBLIC AGENCY (Give name)					
B. <input type="checkbox"/> PRIVATE INSURANCE D. <input type="checkbox"/> EMPLOYER OR UNION F. <input type="checkbox"/> OTHER (Explain)					
15. PATIENT'S CERTIFICATION: AUTHORIZATION TO RELEASE INFORMATION AND PAYMENT REQUEST: I certify that the information given by me in applying for payment under Title XVIII of the Social Security Act is correct. I authorize release of all records required to act on this request. I request that payment of authorized benefits be made in my behalf.					
SIGNATURE (Patient or authorized representative) (Signature by mark must be witnessed)					DATE
16. DIAGNOSES					17. LEAVE BLANK
EMPLOYMENT RELATED A. <input type="checkbox"/> YES B. <input type="checkbox"/> NO (If yes, give name and address of employer.)					
REPORT OF ELIGIBILITY					
A. EFFECTIVE DATE, HOSPITAL INSURANCE				J. OPEN ITEM	
B. EFFECTIVE DATE, MEDICAL INSURANCE				1. INTERMEDIARY	
C. DATE OF START OF CARE					
D. HOSPITAL INSURANCE VISITS AVAILABLE					
E. MEDICAL INSURANCE VISITS AVAILABLE					
F. LAST DISCHARGE DATE				2. PROVIDER	
G. MEDICAL PLAN DEDUCTIBLE <input type="checkbox"/> MET <input type="checkbox"/> NOT MET					
H. OUTPATIENT PSYCHIATRIC EXPENSE <input type="checkbox"/> MET <input type="checkbox"/> NOT MET				3. ADMITTED	
I. REMARKS				4. DISCHARGED	
APPROVED BY				DATE	
FORM SSA-1487 (4-66)					
ADMISSION COPY					

EXHIBIT 5

DISTRICT OFFICE

DEPARTMENT OF  
HEALTH, EDUCATION, AND WELFARE  
SOCIAL SECURITY ADMINISTRATION

CLAIM NUMBER

**Certificate of Social Insurance Award**

PAYMENT CENTER:

DATE:



THIS IS TO CERTIFY THAT THE PERSON(S) NAMED BELOW BECAME ENTITLED TO THE INSURANCE BENEFITS SHOWN,  
PAYABLE UNDER TITLE II OF THE SOCIAL SECURITY ACT.

NAME AND ADDRESS OF PAYEE AS THE CLAIMANT  
OR AS REPRESENTATIVE OF THE CLAIMANT

DATE OF  
ENTITLEMENT

MONTHLY  
BENEFIT

AMOUNT OF  
FIRST CHECK

TYPE OF BENEFIT:

The right to receive social security benefits carries with it certain responsibilities. They are explained in the enclosed booklet. Read this booklet carefully. Be sure that you understand clearly what you can expect by way of benefits, and what is to be expected of you.

NOTICE: If you believe that this determination is not correct, you may request that your case be reexamined. If you want this reconsideration, you must request it not later than 6 months from the date of this notice. You may make any such request through your social security office. If additional evidence is available, you should submit it with your request.

ROBERT M. BALL  
COMMISSIONER OF SOCIAL SECURITY

FORM OA-30 (2-66)

KEEP AS A PERMANENT RECORD—DO NOT DESTROY



EXHIBIT 6

TEMPORARY NOTICE OF ELIGIBILITY

District Office Address:

Date:

Dear \_\_\_\_\_ :

Based on the information you have given to the Social Security Administration you will be eligible for hospital insurance benefits beginning (mo.) (yr.) and for supplementary medical insurance benefits beginning (mo.) (yr.). Your eligibility will continue for 60 days from the date shown at the top of this notice unless you are notified otherwise during the 60-day period.

To obtain medical services before you receive your card, show this letter to your hospital or doctor but keep the letter with you. This temporary notice of eligibility is to be used only by the person to whom it is addressed. Misuse is unlawful and will make the offender liable to a penalty.

This letter should be destroyed as soon as you receive your health insurance card or other notice concerning your eligibility.

Sincerely yours,

Robert M. Ball  
Commissioner of Social Security

IMPORTANT

When services are provided on the basis of this notice, all bills or correspondence with an intermediary or the Social Security Administration should show the patient's social security claim number.

## Chapter IV

### HOME HEALTH AGENCY BILLING PROCEDURES

	Section	Page
Interviewing the patient about his deductible status .....	400	41
General billing information .....	401	41
Completion of HHA billing (Form SSA-1487) .....	405	41
Disposition of Form SSA-1487 .....	405. 1	45
Transfer from Part A to Part B home health services .....	410	45
Transfer from Part B to Part A home health services .....	411	45
Effect of a new spell of illness .....	412	45
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Transfer to another agency under the same home health plan of treatment .....	415	46
Home health services are suspended or terminated, then reinstated .....	425	46
Preparation of a home health billing form in no-payment situations .....	430	47
Home health services under Part B extended from one calendar year into the follow- ing calendar year .....	440	47
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Examples .....	450	48
Completing items on Form SSA-1483 .....	460	62





#### 400. INTERVIEWING THE PATIENT ABOUT HIS DEDUCTIBLE STATUS

If it is apparent that the home health services will be charged to supplementary medical insurance rather than to hospital insurance, i.e., there was no prior hospital or extended care facility stay, the plan was not established within 14 days of discharge, benefits were exhausted under a Part A plan, or the home health agency specializes in treating mental diseases, the home health agency will want to discuss the patient's deductible status with him or his representative. (For more detailed information about the deductible, see § 220.1.)

Before the home health agency attempts to collect the \$50 deductible or any portion of it, it should satisfy itself that the deductible has not been met. This should be done by a careful interview with the patient, or a member of his family or other person if he is unable to conduct his own affairs, and by reference to the intermediary's reply to the start of care notice.

The intermediary's reply to the start of care notice will indicate whether the deductible has been met or not met. However, if the reply indicates that the deductible has not been met, there will be no indication of the remaining expenses needed to satisfy the deductible. The patient, in that event, may have a medicare utilization notice or explanation of benefits indicating what part of the deductible he has met. If he has such a notice, the home health agency may collect from the patient the portion of the deductible not met. If the patient has bills for other expenses which could meet the deductible he should submit them promptly to the medical insurance carrier and it will not be necessary for the agency to collect any part of the deductible.

When the intermediary receives the agency's billing, it will query the Social Security Administration central record for the amount of the deductible remaining to be met.

Any overpayments by the patient for the deductible, discovered when the intermediary verifies the status of the deductible with the Social Security Administration, will be refunded to the patient by the intermediary and the agency payment adjusted accordingly.

If the agency collects less than is due, the intermediary will notify it of the amount remaining to be collected on the deductible after processing the bill.

The agency should not bill a third party until the patient's deductible status is known.

**401. GENERAL BILLING INFORMATION**

Form SSA-1487, Home Health Agency Report and Billing should be submitted for covered home health services furnished a Medicare patient under a plan of treatment before visits are exhausted.

Billings should be submitted on a regular basis until the allowable visits are exhausted. An SSA-1487 should be submitted when:

- A. The home health plan of treatment is terminated.
- B. Visits are exhausted.
- C. Visits are switched from Part B to Part A.
- D. Part B visits and other home health services have been rendered and the billing for them will not meet the \$50 deductible.
- E. The patient or his representative refuses to request that payment be made on his behalf. In this case, show "Refused Payment" in the open area under item 22. (Your intermediary can furnish instructions on how to bill if the patient subsequently decides to request payment.)

Services provided in different accounting periods should not be put on the same bill. At the end of your accounting period, you should submit a bill which contains all services furnished to the patient since the last bill and through the end of the period. Services furnished in the next accounting period should be on a separate bill.

Form SSA-1483, Provider Billing for Medical and Other Health Services, should be submitted for certain Part B "medical and other health services" for which a home health agency may receive reimbursement.

1. Patient Not Under a Home Health Plan of Treatment. The home health agency should use an SSA-1483 to bill for certain Part B "medical and other health services" where there is no home health plan of treatment. Specifically, the home health agency may bill for the following services (there must be a physician's certification on file):

- a. Surgical dressings, splints, casts, and other devices used for reduction of fractures and dislocations.
- b. Rental or purchase of durable medical equipment.
- c. Ambulance service operated by the home health agency.
- d. Prosthetic devices.



e. Limb, arm, back, and neck braces, trusses and artificial limbs, arms, and eyes.

f. Outpatient physical therapy services.

**NOTE:** Medical supplies other than as specified in "a" are not covered as "medical and other health services" by Part B of the program.

**2. The Patient Is Under a Home Health Plan of Treatment.** If a patient is receiving home health services under a Part A or Part B plan of treatment, the agency may bill on a SSA-1483 for only the following services (all other services are home health services and should be billed for on an SSA-1487).

a. Ambulance service operated by the home health agency.

b. Purchase of durable medical equipment.

c. Outpatient physical therapy service where the patient chooses to receive physical therapy as a Part B medical and other health service. (Where the patient is receiving home health services under a Part A plan of treatment, physical therapy will usually be furnished as a home health visit because it is usually more advantageous to the patient; i.e., he is not subject to deductible and coinsurance charges. If the patient is receiving home health services under a Part B plan of treatment, he may wish to elect to receive physical therapy services as a medical and other health service to conserve his Part B home health visits. However, refer to § H221 for a discussion of how this decision may affect the home health plan of treatment.)

A start of care notice is not necessary before billing on an SSA-1483. Upon receipt of the SSA-1483, the intermediary will send a Part B query to SSA if the Part B deductible is not met.

#### **405. COMPLETION OF HOME HEALTH AGENCY BILLING (FORM SSA-1487)**

Examples of completed billing forms are in § 450.

Items 1 through 14 should be completed on the initial billing in the manner described in § 325 (start of care notice).

Items 4, 5, 9, 14, 15, and 16 may be omitted on second and subsequent billings. Items 11 and 12 may also be omitted on subsequent billings unless there are later inpatient stays in a hospital or extended care facility (see below).

Items 11 and 12. Name and Address of Institution, etc., and Verified Dates, etc.--The information given



on the initial billing on prior inpatient stays should not be repeated on the second or subsequent billings. However, any subsequent inpatient stays in a hospital or extended care facility should be reported in these items on the next billing. The dates of stay should be entered only if verified with the institution. Once a later inpatient stay has been entered on a billing it should not be repeated on a subsequent billing.

This later information on inpatient admission and discharge is needed to determine if a new spell of illness has begun or the 1-year period for visits has been extended. See § 215.1 for the effect of a later stay on entitlement to Part A home health visits.

Entries in these items do not affect other items on the SSA-1487 unless they start a new spell of illness. The original "Date Care Started" (Item 10) and "Date Home Health Plan Established" (Item 13) will remain the same.

**Item 13. Date Home Health Plan Established.**—Never make more than one entry on a billing form in this item. If Part A visits are involved, the entry is the date the initial plan was established in the spell of illness for which you are billing. The fact the initial plan is amended, the patient is reinstitutionalized in the same spell of illness, Part A visits have been exhausted and Part B visits will begin, care extends from one year into another, etc., is immaterial. This same date could, therefore, be shown on subsequent bills for a number of years. However, a new date plan established is shown if the patient becomes eligible for a new series of Part A visits, regardless of whether he was previously receiving visits under Part A or Part B.

**Item 15. Patient's Certification and Payment Request.**—Have the patient or his authorized representative read the statement on the form or on the agency's record if it uses the alternate signature procedure (see below). If the signature is obtained on Form SSA-1487, it is sufficient if it is legible only on the original.

If the patient cannot sign his name because of his physical or mental condition, another person may sign on his behalf, e.g., John J. Jones by Jack A. Smith. (Obtain a brief statement that shows both why the patient himself did not sign the form and the relationship of the signer to the patient. Retain the explanation in the agency's file if the signature is obtained on the agency's own record. If the signature is on Form SSA-1487, the explanation should accompany or be included in the billing form. In certain situations, a home health agency representative may sign on behalf of the patient. (See § 235.1 for who may sign a request for payment.))

The statement should be read to a patient who signs by mark. A signature by mark should be witnessed by a person who knows the patient.

**Signature on Agency Record.**—The agency may arrange with its intermediary to have the patient's signature on its records serve as the request for payment.

The agency should then incorporate the language now on the SSA-1487 by printing or stamping it on either the agency's own start of care form or on a separate form attached to or associated with that form. The following format is suggested:

**"Statement To Permit Payment for Home Health Services or Hospital Insurance and Medical Insurance Benefits to Home Health Agency**

"I certify that the information given by me in applying for payment under Title XVIII of the Social Security Act is correct. I authorize release of all records required to act on this request. I request that payment of authorized benefits be made on my behalf."

The original copy of the first billing form submitted by the agency for services to a patient should be stamped or typed on the patient's signature line to indicate that the patient's statement is on file. The following wording is suggested: "Patient's request for payment on file."

When the intermediary and agency have arranged to put this procedure into effect, the intermediary will thereafter make payment without the patient's signature on the billing form, as long as home health services are being received from the same agency under the same plan of treatment.

**Item 16. Diagnoses.**—Complete on the initial bill. Home health visits under Part A must be related to a condition for which the patient was receiving inpatient hospital or extended care treatment (see § 240.1). Enter all diagnoses as furnished by the attending physician. List the primary diagnosis first with "Primary" in parentheses.

Show the diagnosis in accordance with recognized nomenclature, e.g., "Current Medical Terminology," or "Standard Nomenclature of Diseases and Operations."

This item need not be completed on subsequent bills, but if other diagnoses are identified between the initial and final bills, note such changes or additional diagnoses on the final bill.

Enter an "X" in the appropriate check box to indicate whether or not the condition is employment re-

lated. If the condition is known to be employment related, enter the name and address of the employer on the initial bill. (See §§ 250-250.2 if workmen's compensation is involved.)

**Item 17. Statement Covers Period.**—Show the beginning and ending dates of the period covered by this bill.

On the first bill for services under a plan of treatment, the "From" date cannot be earlier than the date care started in Item 10.

On the final bill, the "To" date can be no later than the date in Item 20; that is, the date of death, the date discharged, or the date visits are exhausted.

If a patient is discharged or dies after your most recent bill indicated that he was still receiving services, and before receiving additional services, prepare a no-payment bill in accordance with the instructions in § 430.

**Item 18. Date First and Last Visit.**—Do not complete this item. It will be eliminated when the home health billing form is revised.

**Item 19. Patient Status.**—Check only one block to show whether, at the end of the period covered by the bill, the patient is still receiving services, has been discharged, has died, or visits have been exhausted.

In addition to cases in which the patient is discharged because home health services are no longer required, the "Discharged" block will be checked in the following situations:

a. The patient has exhausted his visits and does not need additional home health visits or Part B services.

b. The patient is covered under either Part A or Part B and has exhausted visits under that part although visits will continue.

c. The patient is discharged on the same day visits are exhausted.

d. The patient transfers from Part B to Part A.

e. A stay in the hospital or extended care facility starts a new spell of illness but does not meet the prior stay requirement and the patient is not entitled to Part B.

f. The patient transfers from one agency to another under the same plan of treatment.

g. The final bill for equipment rental.

h. The time limit on Part A visits expires even though the visits are not exhausted. (However, if visits continue under Part B, see § 410.)

The "Visits Exhausted" block will be checked when the patient is covered under both Part A and Part B, has exhausted his visits under both parts and needs

additional home health visits or Part B services

**Item 20. Date Applicable to Item 19.**—A date must be entered in Item 20 if the patient was discharged, died, or his visits were exhausted in the period covered by this bill. It should never be earlier than the "To" date in Item 17.

If the "Still Receives Services" block in Item 19 is checked, make no entry in Item 20.

**Item 21. Statement of Services Rendered.**—From the information received on the start of care notice and other information, the intermediary will advise you whether charges are to be billed under Part A or Part B. If the first billing is under Part A, continue billing under Part A until the patient is discharged, dies, visits are exhausted, a new spell of illness starts, or the year in which visits must be made has ended.

All covered services and items which have been furnished in the billing period must be included in the bill which is being submitted.

**Visits to perform noncovered services should not be shown as visits on the billing form. Some examples of such services are services of a domestic or housekeeping services unrelated to patient care, and meals on wheels. See § 230 and 232 for additional examples. However, see § 430 for rules on submitting no-payment bills.**

Home health services furnished on an outpatient basis at a hospital, extended care facility, or rehabilitation center and billed through the home health agency, should be shown on the billing form as if the home health agency had directly furnished the services. (See §§ 200.2 and 205.7.)

**Note:** Diagnostic services furnished to home health patients in the outpatient department of a participating hospital are not covered home health services and should be billed by the hospital.

**Item 21 A-G.** Show the total number of visits and total charges for each category of services in A through F.

If any home health services are furnished on an outpatient basis (see § 205.7), the initials OP and the number of outpatient visits should be entered in the space immediately following the name of the particular service, e.g., "B. Physical Therapy OP (3)."

If visits are made by individuals in categories other than those listed in A through F, enter the category, (eg., intern) in G with the pertinent number of visits and charges. It is not necessary to show how the charges were determined. For example, if there were 5 one-hour



visits by a home health aide at a charge of \$2 per hour, Item 21F would indicate 5 visits, charges \$10.

The number of visits by and charges for services of an unaccompanied student nurse should be entered in 21A. If a registered nurse who is employed by the home health agency accompanies the student to observe her or the purpose of the student visit is to observe the registered nurse, only one visit should be charged. In either situation such visits and charges would be entered in 21A.

See §§ 218.1 and 218.2 for how to count visits.

**Item 21 H and I.** When an agency bills on the basis of the same charges per unit of service (e.g., visit, week, month) the total number of units will be entered in the unshaded area in H and the charge per unit will be entered in the unshaded area of I (see example below). The number of visits must also be shown in the appropriate category, A through G. No charges need be shown in A through G. No entries should be made in the shaded areas of H and I.

21 STATEMENT OF SERVICES RENDERED		POST-HOSPITAL PLAN		MEDICAL PLAN	
PRIMARY PURPOSE OF VISIT	NO VISITS	CHARGES	NO VISITS	CHARGES	
A. Skilled Nursing Care		\$		\$	
B. Physical Therapy	3				
C. Speech Therapy					
D. Occupational Therapy	2				
E. Medical Social Services	1				
F. Home Health Aide					
G. Other Visits (Specify)					
H. Total No. of Units of Service	6				
I. Charge per unit of Service \$	5.00				
J. TOTALS	6	\$ 30 00		\$	
K. Other (Specify)					
L. TOTAL CHARGES		\$ 30 00		\$	

**Item 21J. Totals.**—Show the total number of visits and total charges listed in A through G. If the agency charges on the basis of a unit of service only, the total charges should be H times I.

**Item 21K. Other.**—Enter in this space charges for covered home health services which are not counted as visits. Enter each medical appliance and category of supply on a separate line with the charge for the item shown on the same line.

See § 420 for payment for rental of equipment when no plan is in effect.

**Item 21L. Total Charges.**—Enter the sum of charges in 21J and 21K. Do not show total visits.

**Item 21M. Amount Paid by Patient.**—This item re-

lates only to amounts paid toward the Part B deductible and coinsurance. On initial bills, only the amounts **actually paid** by or on behalf of the patient in the period covered by the bill should be entered. The actual amount paid by the patient will permit the intermediary to determine if he is entitled to a refund. If the agency collected less than is due, the intermediary will advise it of the exact amount that should be billed for the deductible and coinsurance.

This item should be blank on second and subsequent bills. In subsequent billing periods, the agency is responsible for making the refund to the patient if deductible and coinsurance amounts are overcollected.

**Item 22. Computing Reimbursement Under Part A (Post-Hospital Plan).**—This item is designed to determine the interim amount payable under Part A. The computation may be made either by the agency or the intermediary.

**Item 22A. Total Charges.**—Enter the total Part A (post-hospital plan) charges from Item 21L.

**Item 22B. Reimbursement Rate.**—Show the reimbursement rate agreed upon by the agency and the intermediary. It is the **percentage** relationship of the agency's costs to its charges.

**Item 22C. Reimbursement Amount A Times B.**—Multiply the total charges (22A) by the reimbursement percentage rate (22B) to determine the interim reimbursement amount.

**Item 23. Computing Reimbursement Under Part B (Medical Plan).**—The agency should **not** complete this item unless it knows that the \$50 deductible has been met.

**Item 23A. Verified Deductible.**—If the deductible has been met, enter "0" (zero). If you do not know that the deductible has been met, make no entry.

**Item 23B. Verified Coinsurance.**—If the deductible has been met, enter 20 percent of the total medical plan charges in Item 21L.

**Item 23C. Total Charges.**—Enter the amount shown in the medical plan column in Item 21L.

**Item 23D. Reimbursement Rate.**—This must **always** be a percentage. It will be the percentage relationship of the agency's costs to its charges.

**Item 23E. C Times D.**—Enter the total charges (Item 23C) multiplied by the reimbursement rate (Item 23D).

**Item 23F. E Less A.**—If the deductible has been met, enter the Item 23E amount. If the deductible has not been met, make no entry.



**Item 23G. Reimbursement Amount 80 Percent of F.--Multiple Item 23F by 80 percent.** (It is important to note that even though the deductible to be met exceeds total charges a payment to the agency is possible if the reimbursement rate (Item 23D) is over 100 percent. **Example:** Deductible to be met is \$20, total charges \$15, reimbursement rate 150 percent. Charges times rate is \$22.50, subtracting \$15 of the deductible (see item 23A) leaves \$7.50; 80 percent of \$7.50 is \$6. The intermediary would make this computation.)

**Item 23H. Refund to Patient.**—The intermediary will complete this item.

**Item 23I. Net Amount to Agency, G Less H.**—The intermediary will complete this item.

**Certification and Signature Line.**—An agency representative should make sure that the required physician's certification and recertification are in the agency's records. The representative should then sign and date the form before it is submitted to the intermediary. A stamped signature is acceptable. The date forwarded should be the date the bill is actually forwarded to the intermediary; it should not be before the "To" date in the "Statement Covers Period" item.

**405.1 Disposition of Form SSA-1487.**—Retain the copy designated "Home Health Agency Copy" and submit the remaining copies to your intermediary (or SSA in direct dealing situations). The remaining copies to be submitted to the intermediary or SSA are the following:

- a. The original copy which is maintained in the intermediary's (or SSA Direct Reimbursement's) files.
- b. The copy designated "Social Security Administration Copy."

Where the notice of admission copies of the form have not been used for start of care notice purposes they may be discarded.

#### **410. TRANSFER FROM PART A TO PART B HOME HEALTH SERVICES**

If a patient will receive Part B services under the same home health plan of treatment after Part A visits are exhausted, or the time limit for Part A visits has run out, submit separate bills for each part. Do not submit a start of care notice. On the last bill for Part A services, the "still receives services" block in Item 19 is checked.

On the initial bill for Part B services Items 10 and 13 will contain the same dates as on the billings for Part A services.

#### **411. TRANSFER FROM PART B TO PART A HOME HEALTH SERVICES**

If a patient receiving Part B services has a qualifying inpatient stay so that visits under Part A will commence, separate bills must be submitted for each part. The discharge billing for the services under Part B should contain the following information:

**Item 17. "To Date"**—Date of admission to the qualifying hospital or extended care facility stay.

**Item 19. "Discharged"** block should be checked.

**Item 20. "Date applicable to Item 19"**—Date of admission to the qualifying hospital or extended care facility stay.

A start of care notice must be submitted and processed in the usual manner. On the start of care notice and Part A billing complete Items 10, 13, and 17 as follows:

**Item 10.** Show the date on which care started under the Part A plan.

**Item 13.** Show the date on which the new plan for visits under Part A was established.

**Item 17. "From Date"** is the date care started under the Part A plan.

#### **412. EFFECT OF A NEW SPELL OF ILLNESS**

If a patient receiving visits under Part A has an inpatient stay in a qualified institution (see § 112.3), which occurs more than 60 days after his last discharge from an institution which prolongs a spell of illness (see § 112.3), a new spell of illness starts. This terminates the Part A plan of treatment. The agency should prepare a final billing. The "Discharged" block in Item 19 will be checked (and the first day of the inpatient stay entered in Item 20) unless the patient will receive Part B services under the same plan of treatment (see § 410).

If Part A home health visits are resumed after this inpatient stay a new start of care notice is required. If the inpatient stay meets the prior stay requirement (§ 210.2) the new plan will be under Part A, if not, it must be under Part B.

If a patient receiving Part B visits has an inpatient stay which starts a spell of illness and meets the prior stay requirement, § 411 should be followed. If prior stay requirements are not met, Part B visits can continue. In the latter case the information on the inpatient stay should be entered in Items 11 and 12 of the next billing form submitted.

#### **413. MORE THAN ONE AGENCY FURNISHES HOME HEALTH SERVICES**

In the exceptional case where a physician deems it necessary to use two participating home health agencies, the physician will designate the agency which will render the major services and assume the major responsibility for the patient's total care as the primary agency.

Although services can be provided by both agencies, the primary agency will submit the start of care notice, bill for all the services rendered by both agencies to the patient, and keep all the records pertaining to the case including the plan of treatment, required certifications, and the record of the number of visits to be charged against the patient's allowable maximum. The secondary agency will be reimbursed through the primary agency under mutually agreed upon arrangements.

In rare instances a patient is under the care of two physicians, and each physician finds it necessary to establish a home health plan with different agencies to secure required services. Each agency will independently submit a start of care notice and bill for the services it renders.

If it comes to the attention of one home health agency that a patient is receiving services from another agency each agency providing services to the same patient should, to the extent possible, keep the other agency advised of the visits, etc., furnished by it. This will permit each agency involved to keep track of the number of visits furnished the patient.

#### **415. TRANSFER TO ANOTHER AGENCY UNDER THE SAME HOME HEALTH PLAN OF TREATMENT**

If a patient transfers from one agency to another and the current home health services are a continuation of the original plan of treatment, the first agency will indicate in Item 19 on its final bill that the patient has been "discharged," and insert the day its records are transferred to the other agency in Item 20.

The second agency (after submitting a start of care notice) will bill as though it is the initial provider under that particular plan. The bills will continue to show in Item 10 the original date care was started by the first agency, etc. On the first bill the second agency submits, the billing period in Item 17 will be from the day of the first agency's transfer to the end of the billing period.

#### **425. HOME HEALTH SERVICES ARE SUSPENDED OR TERMINATED THEN REINSTATED**

A physician may feel it necessary to suspend visits for a time to determine whether the patient is sufficiently recovered from his condition to do without further home health services. When the suspension is temporary (not more than 60 days) and the physician later determines that the services must be resumed,



the resumed services will be paid under the same program (Part A or Part B) and plan of treatment as before the suspension. No special entry is needed on the bill to indicate a suspension. The date care started (Item 10) and the date plan established (Item 13) will remain the same as on the initial bill. A no-payment bill should not be submitted for the period in which there were no visits.

For purposes of medicare reimbursement, a suspension of home health visits for more than 60 days terminates the plan of treatment. When this occurs, a discharge bill is prepared by the agency. To qualify for additional Part A home health visits, the patient must have a new qualifying inpatient stay, and a new start of care notice must be submitted.

There may also be instances in which a physician determines that home health services being furnished under Part A are no longer necessary and discharges the patient. The physician may later determine that the home health services are again necessary and may establish a plan for services related to the same condition for which the individual was previously hospitalized. However, since the previous plan of treatment was terminated, the subsequent services cannot be paid under Part A unless the patient has had an intervening qualifying inpatient stay. A new start of care notice must be submitted if the patient again qualifies for home health visits.

#### **440. PREPARATION OF A HOME HEALTH BILLING FORM IN NO-PAYMENT SITUATIONS**

Although no payment will be made, a home health billing form should be submitted when:

- a. Workmen's compensation has paid or can be expected to pay the entire bill.
- b. A National Institutes of Health grant paid or will pay the entire bill.
- c. The patient is discharged from home health visits or dies after an earlier bill indicated that he was still receiving services, and no visits have been made during the interim period. In this situation, the date of discharge or death must be later than the "To Date" shown in Item 17 on the earlier bill.

On a no-payment bill, only the following entries should be completed:

- a. Item 1. Patient's name.
- b. Item 2. Health Insurance Claim Number.
- c. Item 7. Provider Number.
- d. Item 10. Date Care Started.
- e. Item 16. Diagnoses and whether illness was employment related.
- f. Item 19. Terminating Action. If Item 19 does not provide the reason for nonpayment, e.g., workmen's compensation, enter reason in open area under Item 22.
- g. Item 20. Date Applicable to Item 19.
- h. Item 21L. Total Charges (this will usually be "None").
- i. Signature of Home Health Agency Representative and Date Forwarded.

**Note:** This abbreviated completion of bills does not apply to two other situations where there will be no reimbursement, i.e., Part B deductible not met, and patient refuses to request payment (§ 401).

#### **440. HOME HEALTH SERVICES UNDER PART B EXTEND FROM ONE CALENDAR YEAR INTO THE FOLLOWING CALENDAR YEAR**

Do not submit a Part B bill for an inclusive period beginning in one calendar year and extending into the following calendar year. If the agency does not normally bill on a calendar month basis, it must prepare two bills. The first will cover the period ending December 31 of the old year, the second, the period beginning January 1 of the new year. This will permit the intermediary to apply the appropriate deductible for both years. A new start of care notice is not required for the period beginning in the new year.

#### **445. PROCEDURES FOR SUBMITTING CORRECTED BILLS**

To correct a previously submitted bill, the home health agency should reproduce a legible copy of the submitted bill. Corrections should be made in red in the appropriate item(s). The corrected bill should be marked "DEBIT-ADJ" in the upper right-hand margin. If all charges and days reported on the previously submitted bill are to be deleted, mark it "CANCEL ONLY" in the upper right-hand margin. Send the corrected bill to the intermediary.



#### 450. EXAMPLES

- I. Initial Billing—Part A Visits.
- II. Subsequent Billing—Part A—Less Than 3-Day Hospital Stay During Billing Period.
- III. Subsequent Billing—Part A—3 (or More) Day Hospital Stay.
- IV. Discharge Billing—Part A—New Spell of Illness.
- V. Initial Billing—Part A—After Transfer From Another Agency.
- VI. Final Billing—Part A—Services Continue but Part A Visits Exhausted.

VII. Initial Billing—Part B—Part A Visits Exhausted.

VIII. Subsequent Billing—Part B—Less Than 3-Day Hospital Stay.

IX. Final Billing—Part B—Patient Qualifies for Part A.

X. Initial Billing—Part A—Equipment Furnished as Home Health Service.

XI. Final Billing—Part A—Physician Terminates Plan—Equipment Still Needed.

XII. Billing for Rental of Equipment—Part B.

## Example I

### I. INITIAL BILLING—PART A—VISITS

John H. Doe has a qualifying inpatient stay April 3, 1967, through April 8, 1967. A home health plan is established April 9, 1967, and care is started on April 10, 1967.

The home health agency submits a start of care notice. The official transfer records furnished this agency contain the inpatient stay dates and are entered in Item 12. The patient's signature is not required since the agency has obtained it on a form maintained in its own records.

The agency receives a reply which indicates (a) the patient is entitled to Part A and Part B, (b) he has 100 visits remaining under both plans, (c) the Part B deductible is met.

The agency charges a unit rate of \$5.00 a visit and the agreed-upon reimbursement rate is 110%. Since the agency has a uniform rate for all services no charges are entered in Items 21A through 21G.

At the end of its monthly billing period the agency submits its billing as below.

DEPARTMENT OF HEALTH, EDUCATION AND WELFARE SOCIAL SECURITY ADMINISTRATION <b>HOME HEALTH AGENCY REPORT AND BILLING</b> HOSPITAL AND MEDICAL INSURANCE BENEFITS—SOCIAL SECURITY ACT										Form Approved Budget Bureau No. No. 72-R736			
1. PATIENT'S LAST NAME <b>Doe</b>		FIRST NAME <b>John</b>		MI <b>H</b>	2. HEALTH INSURANCE CLAIM NUMBER <b>000-00-0000 A</b>								
3. PATIENT'S ADDRESS (Street number, City, State, Zip Code) <b>6401 Security Blvd., Baltimore, Md. 21235</b>					4. DATE OF BIRTH <b>02 09 29</b>		5. SEX <input checked="" type="checkbox"/> M <input type="checkbox"/> F						
6. HOME HEALTH AGENCY NAME AND ADDRESS <b>X Visiting Nurse Association 110 South Paca St. Baltimore, Md. 21201</b>				7. PROVIDER NO <b>000 000</b>		9. NAME AND ADDRESS OF ATTENDING PHYSICIAN <b>William Jones, M.D. 6401 Uben Blvd. Baltimore, Md. 21201</b>							
10. DATE CARE STARTED <b>04 10 67</b>				11. NAME AND ADDRESS OF INSTITUTION, IF ANY, CARING FOR CONDITION LATER REQUIRING HOME HEALTH SERVICES <b>General Hospital 100 Bruce Street Baltimore, Maryland 21201</b>				12. VERIFIED DATES OF STAY IN ITEM 11 FROM <b>04 03 67</b> TO <b>04 08 67</b>		13. DATE HOME HEALTH PLAN ESTABLISHED <b>04 09 67</b>			
14. PAYMENT SOURCE FOR CHARGES TO PATIENT A. <input type="checkbox"/> SELF OR FAMILY    C. <input type="checkbox"/> BLUE CROSS    E. <input type="checkbox"/> PUBLIC AGENCY (Give name) B. <input type="checkbox"/> PRIVATE INSURANCE    D. <input checked="" type="checkbox"/> EMPLOYER OR UNION    F. <input type="checkbox"/> OTHER (Explain)													
15. PATIENT'S CERTIFICATION: AUTHORIZATION TO RELEASE INFORMATION AND PAYMENT REQUEST: I certify that the information given by me in applying for payment under Title XVIII of the Social Security Act is correct. I authorize release of all records required to act on this request. I request that payment of authorized benefits be made in my behalf.													
SIGNATURE (Patient or authorized representative) (Signature by mark must be witnessed)										DATE <b>04/09/67</b>			
Patient's Request for Payment on File 16. DIAGNOSES <b>Cerebral Vascular Accident</b> EMPLOYMENT RELATED A. <input type="checkbox"/> YES B. <input checked="" type="checkbox"/> NO (If yes, give name and address of employer)													
17. STATEMENT COVERS PERIOD FROM <b>04 10 67</b> TO <b>04 30 67</b>										18. DATE OF FIRST VISIT		19. PATIENT <input type="checkbox"/> DIS-CHARGED <input checked="" type="checkbox"/> STILL RECEIVES SERVICES <input type="checkbox"/> DIED <input type="checkbox"/> VISITS EXHAUSTED	
20. DATE APPLICABLE TO ITEM 19													
21. STATEMENT OF SERVICES RENDERED													
PRIMARY PURPOSE OF VISIT		NO VISITS		CHARGES		NO VISITS		CHARGES		22. POST-HOSPITAL PLAN			
A. Skilled Nursing Care				\$				\$		A TOTAL CHARGES <b>\$40.00</b>			
B. Physical Therapy		6								B REIMBURSEMENT RATE <b>110%</b>			
C. Speech Therapy										C TOTAL CHARGES			
D. Occupational Therapy										D REIMBURSEMENT RATE			
E. Medical Social Services		1								E C TIMES D			
F. Home Health Aide		1								F E LESS A			
G. Other Visits (Specify)										G REIMBURSEMENT AMT 80% OF F			
H. Total No. of Units of Service		8								H REFUND TO PATIENT			
I. Charge per unit of Service		\$5.00								I NET AMOUNT TO AGENCY, G LESS H			
J. TOTALS		8		\$ 40 00		\$							
K. Other (Specify)													
L. TOTAL CHARGES				\$ 40 00		\$							
M. AMOUNT PAID BY PATIENT						\$							
I certify that required physician's certification and recertifications are on file.													
SIGNATURE OF HOME HEALTH AGENCY REPRESENTATIVE <b>/s/ Edward Roberts</b>						DATE FORWARDED <b>05 02 67</b>		APPROVED BY <b>/s/ Joseph Cole</b>		DATE APPROVED <b>05 09 67</b>			
FORM SSA-1487 (4-66) HOME HEALTH AGENCY COPY													

## II. SUBSEQUENT BILLING—PART A—LESS THAN 3-DAY HOSPITAL STAY DURING BILLING PERIOD

Since this is a subsequent bill only the items indicated

The hospital stay extends the spell of illness, but does not establish a new 1-year period for Part A visits since it was for less than 3 days.

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10/67



### Example III

## III. SUBSEQUENT BILLING—PART A—3 (OR MORE) DAY HOSPITAL STAY

The patient continues to receive visits. He is rehospitalized from June 10, 1967, to June 17, 1967.

Since he was an inpatient for at least 3 consecutive

days, the period in which he must use his 100 visits has been extended to June 16, 1968.

DEPARTMENT OF HEALTH, EDUCATION, AND WELFARE SOCIAL SECURITY ADMINISTRATION		HOME HEALTH AGENCY REPORT AND BILLING HOSPITAL AND MEDICAL INSURANCE BENEFITS—SOCIAL SECURITY ACT		Form Approved Budget Bureau No. No. 72-8736	
1. PATIENT'S LAST NAME <b>Doe</b>		2. FIRST NAME <b>John</b>		3. HEALTH INSURANCE CLAIM NUMBER <b>000-00-0000 A</b>	
4. PATIENT'S ADDRESS (Street number, City, State, Zip Code) <b>6401 Security Blvd., Baltimore, Md. 21235</b>		5. DATE OF BIRTH <b>06/10/67</b>		6. SEX <input checked="" type="checkbox"/> M <input type="checkbox"/> F	
7. HOME HEALTH AGENCY NAME AND ADDRESS <b>I Visiting Nurse Association 110 South Paca Street Baltimore, Maryland 21201</b>		8. PROVIDER NO. <b>000 000</b>		9. NAME AND ADDRESS OF ATTENDING PHYSICIAN	
10. DATE CARE STARTED <b>06/10/67</b>		11. NAME AND ADDRESS OF INSTITUTION, IF ANY, CARING FOR CONDITION LATER REQUIRING HOME HEALTH SERVICES <b>General Hospital 100 Bruce Street Baltimore, Maryland 21201</b>		12. VERIFIED DATES OF STAY IN ITEM 11 FROM <b>06/10/67</b> TO <b>06/17/67</b>	
13. DATE HOME HEALTH PLAN ESTABLISHED <b>06/09/67</b>		14. PAYMENT SOURCE FOR CHARGES TO PATIENT A. <input type="checkbox"/> SELF OR FAMILY C. <input type="checkbox"/> BLUE CROSS BLUE SHIELD E. <input type="checkbox"/> PUBLIC AGENCY B. <input type="checkbox"/> PRIVATE INSURANCE D. <input type="checkbox"/> EMPLOYER OR UNION F. <input type="checkbox"/> OTHER (Explain)		15. PATIENT'S CERTIFICATION: AUTHORIZATION TO RELEASE INFORMATION AND PAYMENT REQUEST: I certify that the information given by me in applying for payment under Title XVIII of the Social Security Act is correct. I authorize release of all records required to act on this request. I request that payment of authorized benefits be made in my behalf.	
SIGNATURE (Patient or authorized representative) (Signature by mark must be witnessed)		DATE			
16. DIAGNOSES		EMPLOYMENT RELATED A. <input type="checkbox"/> YES B. <input type="checkbox"/> NO (If yes, give name and address of employer.)		LEAVE BLANK	
17. STATEMENT COVERS PERIOD FROM <b>06/01/67</b> TO <b>06/30/67</b>		18. DATE OF FIRST VISIT		19. PATIENT <input type="checkbox"/> DIS-CHARGED <input checked="" type="checkbox"/> STILL RECEIVES SERVICES <input type="checkbox"/> DIED <input type="checkbox"/> VISITS EXHAUSTED	
20. DATE APPLICABLE TO ITEM 19		21. STATEMENT OF SERVICES RENDERED		22. POST-HOSPITAL PLAN	
		23. MEDICAL PLAN		24. MEDICAL PLAN	
PRIMARY PURPOSE OF VISIT		NO. VISITS		CHARGES	
A. Skilled Nursing Care		4		\$20.00	
B. Physical Therapy		4		110%	
C. Speech Therapy				22.00	
D. Occupational Therapy					
E. Medical Social Services					
F. Home Health Aide					
G. Other Visits (Specify)					
H. Total No. of Units of Service		4			
I. Charge per unit of Service		\$5.00			
J. TOTALS		4		\$20.00	
K. Other (Specify)					
L. TOTAL CHARGES		\$20.00		\$	
M. AMOUNT PAID BY PATIENT				\$	
I certify that required physician's certification and recertifications are on file.		SIGNATURE OF HOME HEALTH AGENCY REPRESENTATIVE <b>/s/ Edward Roberts</b>		DATE FORWARDED <b>07/07/67</b>	
		APPROVED BY <b>/s/ Joseph Cole</b>		DATE APPROVED <b>07/14/67</b>	
FORM SSA-1487 (4-66)		HOME HEALTH AGENCY COPY			

## Example IV

### IV. DISCHARGE BILLING—PART A—NEW SPELL OF ILLNESS

The patient was expected to continue receiving Part A visits although none had been made in August. On August 18, 1967, he was admitted to a qualified hospital. He was discharged from the hospital on August 24, 1967.

A new spell of illness begins because the beneficiary was not an inpatient in the 60 days preceding this pe-

riod of hospitalization. The patient is entitled to a new series of 100 Part A home health visits in the year beginning with his discharge on August 24, 1967.

The agency prepares a discharge bill. Item 17 shows the billing period as August 1, 1967, to August 18, 1967, the date the beneficiary was hospitalized. August 18 is also shown in Item 20.

DEPARTMENT OF HEALTH, EDUCATION AND WELFARE SOCIAL SECURITY ADMINISTRATION <b>HOME HEALTH AGENCY REPORT AND BILLING</b> <b>HOSPITAL AND MEDICAL INSURANCE BENEFITS—SOCIAL SECURITY ACT</b>										Form Approved Budget Bureau No. No. 72-R736	
1. PATIENT'S LAST NAME <b>Doe</b>			FIRST NAME <b>John</b>		MI <b>H</b>	2. HEALTH INSURANCE CLAIM NUMBER <b>000-00-0000 A</b>					
3. PATIENT'S ADDRESS (Street number, City, State, Zip Code) <b>6401 Security Blvd., Baltimore, Md. 21235</b>						4. DATE OF BIRTH ____/____/____		5. SEX <input type="checkbox"/> M <input type="checkbox"/> F			
6. HOME HEALTH AGENCY NAME AND ADDRESS <b>I Visiting Nurse Association 110 South Paca St. Baltimore, Md.</b>				7. PROVIDER NO. <b>000 000</b>		9. NAME AND ADDRESS OF ATTENDING PHYSICIAN					
				8. MEDICAL RECORD NO.							
10. DATE CARE STARTED <b>0 8   1 0   6 7</b>			11. NAME AND ADDRESS OF INSTITUTION, IF ANY, CARING FOR CONDITION LATER REQUIRING HOME HEALTH SERVICES				12. VERIFIED DATES OF STAY IN ITEM 11 FROM ____ TO ____		13. DATE HOME HEALTH PLAN ESTABLISHED		
14. PAYMENT SOURCE FOR CHARGES TO PATIENT											
A <input type="checkbox"/> SELF OR FAMILY    C <input type="checkbox"/> BLUE CROSS BLUE SHIELD    E <input type="checkbox"/> PUBLIC AGENCY (Give name) B <input type="checkbox"/> PRIVATE INSURANCE    D <input type="checkbox"/> EMPLOYER OR UNION    F <input type="checkbox"/> OTHER (Explain)											
15. PATIENT'S CERTIFICATION: AUTHORIZATION TO RELEASE INFORMATION AND PAYMENT REQUEST: I certify that the information given by me in applying for payment under Title XVIII of the Social Security Act is correct. I authorize release of all records required to act on this request. I request that payment of authorized benefits be made in my behalf.											
SIGNATURE (Patient or authorized representative) (Signature by mark must be witnessed)										DATE	
16. DIAGNOSES											
EMPLOYMENT RELATED    A <input type="checkbox"/> YES    B <input type="checkbox"/> NO (If yes, give name and address of employer.)										LEAVE BLANK	
17. STATEMENT COVERS PERIOD											
FROM		TO		18. DATE OF FIRST VISIT		DATE OF LAST VISIT		19. PATIENT		20. DATE APPLICABLE TO ITEM 19	
<b>08   01   67</b>		<b>08   18   67</b>						<input checked="" type="checkbox"/> DIS-CHARGED <input type="checkbox"/> STILL RECEIVES SERVICES <input type="checkbox"/> DIED <input type="checkbox"/> VISITS EXHAUSTED		<b>0 8   1 8   6 7</b>	
21. STATEMENT OF SERVICES RENDERED				POST-HOSPITAL PLAN		MEDICAL PLAN		22. POST-HOSPITAL PLAN		23. MEDICAL PLAN	
PRIMARY PURPOSE OF VISIT				NO VISITS		CHARGES		A. TOTAL CHARGES		A. VERIFIED DEDUCTIBLE	
A. Skilled Nursing Care											
B. Physical Therapy								B. REIMBURSEMENT RATE		B. VERIFIED COINSURANCE	
C. Speech Therapy											
D. Occupational Therapy								C. REIMBURSEMENT AMT A TIMES 8		C. TOTAL CHARGES	
E. Medical Social Services										D. REIMBURSEMENT RATE	
F. Home Health Aide										E. C TIMES D	
G. Other Visits (Specify)										F. E LESS A	
H. Total No. of Units of Service										G. REIMBURSEMENT AMT 80 % OF F	
I. Charge per unit of Service \$										H. REFUND TO PATIENT	
J. TOTALS				\$		\$				I. NET AMOUNT TO AGENCY: G LESS H	
K. Other (Specify)											
L. TOTAL CHARGES				\$ None		\$					
M. AMOUNT PAID BY PATIENT						\$					
I certify that required physician's certification and recertifications are on file.											
SIGNATURE OF HOME HEALTH AGENCY REPRESENTATIVE						DATE FORWARDED		APPROVED BY		DATE APPROVED	
/s/ Edward Roberts						0 8   2 8   6 7		/s/ Joseph Cole		0 8   3 1   6 7	
FORM SSA-1487 (4-66)											HOME HEALTH AGENCY COPY

## Example V

### V. INITIAL BILLING—PART A—AFTER TRANSFER FROM ANOTHER AGENCY

On the basis of Mr. Doe's qualifying inpatient stay, August 18, 1967, to August 24, 1967, a new home health plan was established. Visits will now be made by another home health agency.

A new start of care notice shows the plan was established August 25, 1967, and the care started August 26, 1967. The official transfer records furnished this home health agency contain the inpatient stay dates and are

therefore entered in Item 12. The home health agency has the patient sign the SSA-1487.

The home health agency charges on a visit basis but has different rates according to the type of visit. The agreed-upon reimbursement rate is 90%.

On September 14 the agency submits the billing shown below.

DEPARTMENT OF HEALTH, EDUCATION AND WELFARE SOCIAL SECURITY ADMINISTRATION <b>HOME HEALTH AGENCY REPORT AND BILLING</b> HOSPITAL AND MEDICAL INSURANCE BENEFITS—SOCIAL SECURITY ACT										Form Approved Budget Bureau No. No. 72-R736																																																																																					
1. PATIENT'S LAST NAME <b>Doe</b>			2. FIRST NAME <b>John</b>		3. MI <b>H</b>		4. HEALTH INSURANCE CLAIM NUMBER <b>000-00-0000 A</b>																																																																																								
5. PATIENT'S ADDRESS (Street number, City, State, Zip Code) <b>6401 Security Blvd., Baltimore, Md. 21235</b>							6. DATE OF BIRTH <b>0 9 0 9 9 9</b>		7. SEX <input checked="" type="checkbox"/> M <input type="checkbox"/> F																																																																																						
8. HOME HEALTH AGENCY NAME AND ADDRESS <b>Neighborhood Nurse Association 425 East 165th, West Baltimore, Md. 21207</b>					9. PROVIDER NO. <b>000 000</b>		10. NAME AND ADDRESS OF ATTENDING PHYSICIAN <b>Paul Taylor, M.D. 101 North Paca Street Baltimore, Md. 21203</b>																																																																																								
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## Example VI

### VI. FINAL BILLING—PART A—SERVICES CONTINUE BUT PART A VISITS EXHAUSTED

Mr. Doe receives Part A home health visits until March 15, 1968, when the 100 visits are exhausted. The home health agency now transfers him to Part B visits.

The agency must submit two bills for the month of

March, one for the Part A visits and one for the Part B visits.

This example VI shows the information to be entered on the Part A bill.

See Example VII for the Part B bill.

DEPARTMENT OF HEALTH, EDUCATION AND WELFARE SOCIAL SECURITY ADMINISTRATION <b>HOME HEALTH AGENCY REPORT AND BILLING</b> HOSPITAL AND MEDICAL INSURANCE BENEFITS—SOCIAL SECURITY ACT										Form Approved Budget Bureau No. No. 72-R736	
1. PATIENT'S LAST NAME <b>Doe</b>			2. FIRST NAME <b>John</b>		3. MI <b>H</b>	4. HEALTH INSURANCE CLAIM NUMBER <b>000-00-0000 A</b>					
5. PATIENT'S ADDRESS (Street number, City, State, Zip Code) <b>6401 Security Blvd., Baltimore, Md. 21235</b>						6. DATE OF BIRTH		7. SEX <input type="checkbox"/> M <input type="checkbox"/> F			
8. HOME HEALTH AGENCY NAME AND ADDRESS <b>Neighborhood Nurse Association 425 East 165th, West Baltimore, Md. 21207</b>						9. PROVIDER NO <b>000 000</b>		10. NAME AND ADDRESS OF ATTENDING PHYSICIAN			
						11. MEDICAL RECORD NO					
12. DATE CARE STARTED <b>08 26 67</b>		13. NAME AND ADDRESS OF INSTITUTION, IF ANY, CARING FOR CONDITION LATER REQUIRING HOME HEALTH SERVICES				14. VERIFIED DATES OF STAY IN ITEM 11 FROM TO		15. DATE HOME HEALTH PLAN ESTABLISHED <b>08 25 67</b>			
16. PAYMENT SOURCE FOR CHARGES TO PATIENT A <input type="checkbox"/> SELF OR FAMILY    C <input type="checkbox"/> BLUE CROSS    E <input type="checkbox"/> PUBLIC AGENCY (Give name) B <input type="checkbox"/> PRIVATE INSURANCE    D <input type="checkbox"/> EMPLOYER OR UNION    F <input type="checkbox"/> OTHER (Explain)											
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18. SIGNATURE (Patient or authorized representative) (Signature by mark must be witnessed)								19. DATE			
20. DIAGNOSES											
21. EMPLOYMENT RELATED A <input type="checkbox"/> YES B <input type="checkbox"/> NO (If yes, give name and address of employer.)											
22. LEAVE BLANK											
23. STATEMENT COVERS PERIOD FROM TO <b>03 01 68 03 15 68</b>		24. DATE OF FIRST VISIT		25. DATE OF LAST VISIT		26. PATIENT <input type="checkbox"/> DISCHARGED <input checked="" type="checkbox"/> STILL RECEIVES SERVICES <input type="checkbox"/> DIED <input type="checkbox"/> VISITS EXHAUSTED		27. DATE APPLICABLE TO ITEM 19			
28. STATEMENT OF SERVICES RENDERED		29. POST-HOSPITAL PLAN		30. MEDICAL PLAN		31. POST-HOSPITAL PLAN		32. MEDICAL PLAN			
PRIMARY PURPOSE OF VISIT		NO VISITS CHARGES		NO VISITS CHARGES		A. TOTAL CHARGES <b>\$40.00</b>		A. VERIFIED DEDUCTIBLE			
A. Skilled Nursing Care		4 \$ 40.00				B. REIMBURSEMENT RATE <b>90%</b>		B. VERIFIED COINSURANCE			
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I certify that required physician's certification and recertifications are on file.											
SIGNATURE OF HOME HEALTH AGENCY REPRESENTATIVE <b>/s/ Henry Daly</b>					DATE FORWARDED <b>03 20 68</b>		APPROVED BY <b>/s/ Thomas Sides</b>		DATE APPROVED <b>03 28 68</b>		
FORM SSA-1487 (4-66) <span style="margin-left: 50px;">HOME HEALTH AGENCY COPY</span>											

## Example VII

### VII. INITIAL BILLING—PART B—PART A VISITS EXHAUSTED

This example is the bill for Part B visits in March 1968.

The agency believes no part of the \$50 Part B deductible has been met and prematurely collects the total charge of \$40 from the patient. It does not complete Item 23 of the billing form, which the agency completes only when it knows the deductible has been met.

On receipt of the Part B bill for March 1968, the

intermediary queries the SSA central record for deductible status. The reply shows \$30 remaining to meet the Part B deductible for 1968.

The intermediary completes Item 23 to compute the reimbursement amount. A refund of \$8 is determined to be due the patient. The agency has been overpaid \$3.20. This will be adjusted when the agency submits another bill. The intermediary makes the refund to the patient.

DEPARTMENT OF HEALTH, EDUCATION AND WELFARE SOCIAL SECURITY ADMINISTRATION <b>HOME HEALTH AGENCY REPORT AND BILLING</b> HOSPITAL AND MEDICAL INSURANCE BENEFITS—SOCIAL SECURITY ACT										Form Approved Budget Bureau No. No. 72-R736																																																																											
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## Example VIII

### VIII. SUBSEQUENT BILLING—PART B—LESS THAN 3-DAY HOSPITAL STAY

On June 14, 1968, the patient receives inpatient services in a hospital participating in medicare.

This inpatient hospital stay of less than 3 days starts a spell of illness, but does not entitle the patient to visits under Part A. However, information about the

stay is entered in Items 11 and 12 of the next bill.

Since the agency now knows that the Part B deductible was met by its last bill, it may complete Item 23 on this bill.

DEPARTMENT OF HEALTH, EDUCATION AND WELFARE SOCIAL SECURITY ADMINISTRATION <b>HOME HEALTH AGENCY REPORT AND BILLING</b> HOSPITAL AND MEDICAL INSURANCE BENEFITS—SOCIAL SECURITY ACT										Form Approved Budget Bureau No. No. 72-R736	
1. PATIENT'S LAST NAME <b>Doe</b>			FIRST NAME <b>John</b>		M <b>H</b>	2. HEALTH INSURANCE CLAIM NUMBER <b>000-00-0000 A</b>					
3. PATIENT'S ADDRESS (Street number, City, State, Zip Code) <b>6401 Security Blvd., Baltimore, Md. 21235</b>						4. DATE OF BIRTH ____/____/____		5. SEX <input type="checkbox"/> M <input type="checkbox"/> F			
6. HOME HEALTH AGENCY NAME AND ADDRESS <b>Neighborhood Nurse Association 425 East 165th, West Baltimore, Md. 21207</b>				7. PROVIDER NO. <b>000 000</b>		9. NAME AND ADDRESS OF ATTENDING PHYSICIAN					
				8. MEDICAL RECORD NO.							
10. DATE CARE STARTED <b>0 8   2 6   6 7</b>		11. NAME AND ADDRESS OF INSTITUTION, IF ANY, CARING FOR CONDITION LATER REQUIRING HOME HEALTH SERVICES <b>Main Hospital Elm Street Baltimore, Md. 21211</b>				12. VERIFIED DATES OF STAY IN ITEM 11 FROM <b>06   14   68</b> TO <b>06   15   68</b>		13. DATE HOME HEALTH PLAN ESTABLISHED <b>08   25   67</b>			
14. PAYMENT SOURCE FOR CHARGES TO PATIENT A <input type="checkbox"/> SELF OR FAMILY C <input type="checkbox"/> BLUE CROSS BLUE SHIELD E <input type="checkbox"/> PUBLIC AGENCY (Give name) B <input type="checkbox"/> PRIVATE INSURANCE D <input type="checkbox"/> EMPLOYER OR UNION F <input type="checkbox"/> OTHER (Explain)											
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17. STATEMENT COVERS PERIOD FROM <b>06   01   68</b> TO <b>06   30   68</b>		18. DATE OF FIRST VISIT		DATE OF LAST VISIT		19. PATIENT <input type="checkbox"/> DIS-CHARGED <input type="checkbox"/> DIED <input checked="" type="checkbox"/> STILL RECEIVES SERVICES <input type="checkbox"/> VISITS EXHAUSTED		20. DATE APPLICABLE TO ITEM 19			
21. STATEMENT OF SERVICES RENDERED		POST-HOSPITAL PLAN		MEDICAL PLAN		22. POST-HOSPITAL PLAN		23. MEDICAL PLAN			
PRIMARY PURPOSE OF VISIT		NO VISITS		CHARGES		NO VISITS		CHARGES		A. TOTAL CHARGES	
A. Skilled Nursing Care				\$ 1				\$ 10.00		A. VERIFIED DEDUCTIBLE	
B. Physical Therapy				4				40.00		0	
C. Speech Therapy										B. VERIFIED COINSURANCE RATE	
D. Occupational Therapy										\$11.60	
E. Medical Social Services										C. TOTAL CHARGES	
F. Home Health Aide										58.00	
G. Other Visits (Specify)										D. REIMBURSEMENT RATE	
H. Total No. of Units of Service										90%	
I. Charge per unit of Service \$										E. C TIMES D	
J. TOTALS										52.20	
K. Other (Specify)										F. E LESS A	
										52.20	
L. TOTAL CHARGES		\$								G. REIMBURSEMENT AMT 80% OF F	
										41.76	
M. AMOUNT PAID BY PATIENT										H. REFUND TO PATIENT	
										0	
I certify that required physician's certification and recertifications are on file.											
SIGNATURE OF HOME HEALTH AGENCY REPRESENTATIVE <b>/s/ Henry Daly</b>						DATE FORWARDED <b>0 7   1 2   6 8</b>		APPROVED BY <b>/s/ Thomas Sides</b>		DATE APPROVED <b>0 7   1 3   6 8</b>	
FORM SSA-1487 (4-66) HOME HEALTH AGENCY COPY											



## Example IX

### IX. FINAL BILLING—PART B—PATIENT QUALIFIES FOR PART A

From July 4, 1968, to July 8, 1968, Mr. Doe receives inpatient services in a nonparticipating hospital which meets all the conditions of participation. Since a spell of illness started as a result of the June hospitalization, this inpatient stay of 4 days entitles him to a new 100 Part A visits. A new plan must be established.

This example is the final Part B bill. The "To" date

in Item 17 is the same date as shown in Item 20, i.e., the date of admission to the hospital.

Information has also been received by the agency that the Department of Welfare will pay for charges to the patient. The name and address of the agency as well as the case number assigned to the patient are shown in Item 14.

<b>DEPARTMENT OF HEALTH, EDUCATION AND WELFARE</b> <b>SOCIAL SECURITY ADMINISTRATION</b> <b>HOME HEALTH AGENCY REPORT AND BILLING</b> <b>HOSPITAL AND MEDICAL INSURANCE BENEFITS—SOCIAL SECURITY ACT</b>										Form Approved Budget Bureau No. 72-R736	
1. PATIENT'S LAST NAME <b>Doe</b>			2. FIRST NAME <b>John</b>		3. MI <b>H</b>		4. HEALTH INSURANCE CLAIM NUMBER <b>000-00-0000 A</b>				
5. PATIENT'S ADDRESS (Street number, City, State, Zip Code) <b>6401 Security Blvd., Baltimore, Md. 21235</b>							6. DATE OF BIRTH ____/____/____		7. SEX <input type="checkbox"/> M <input type="checkbox"/> F		
8. HOME HEALTH AGENCY NAME AND ADDRESS <b>Neighborhood Nurse Association 125 East 165th, West Baltimore, Md. 21207</b>					9. PROVIDER NO. <b>000 000</b>		10. NAME AND ADDRESS OF ATTENDING PHYSICIAN				
11. MEDICAL RECORD NO.											
12. DATE CARE STARTED <b>0 8   2 6   6 7</b>			13. NAME AND ADDRESS OF INSTITUTION, IF ANY, CARING FOR CONDITION LATER REQUIRING HOME HEALTH SERVICES				14. VERIFIED DATES OF STAY IN ITEM 11 FROM ____ TO ____		15. DATE HOME HEALTH PLAN ESTABLISHED <b>08   25   67</b>		
16. PAYMENT SOURCE FOR CHARGES TO PATIENT A <input type="checkbox"/> SELF OR FAMILY    C <input type="checkbox"/> BLUE CROSS BLUE SHIELD    E <input checked="" type="checkbox"/> PUBLIC AGENCY (Give name) B <input type="checkbox"/> PRIVATE INSURANCE    D <input type="checkbox"/> EMPLOYER OR UNION    F <input type="checkbox"/> OTHER (Explain)											
Department of Welfare 702 Main Street Baltimore, Maryland 21209    Case No. 66464											
17. PATIENT'S CERTIFICATION: AUTHORIZATION TO RELEASE INFORMATION AND PAYMENT REQUEST: I certify that the information given by me in applying for payment under Title XVIII of the Social Security Act is correct. I authorize release of all records required to act on this request. I request that payment of authorized benefits be made in my behalf.											
SIGNATURE (Patient or authorized representative) (Signature by mark must be witnessed)										DATE	
18. DIAGNOSES EMPLOYMENT RELATED    A <input type="checkbox"/> YES    B <input type="checkbox"/> NO    (If yes, give name and address of employer)											
LEAVE BLANK											
19. STATEMENT COVERS PERIOD FROM ____ TO ____		20. DATE OF FIRST VISIT ____/____/____		21. DATE OF LAST VISIT ____/____/____		22. PATIENT <input checked="" type="checkbox"/> DIS-CHARGED <input type="checkbox"/> STILL RECEIVES SERVICES <input type="checkbox"/> DIED <input type="checkbox"/> VISITS EXHAUSTED		23. DATE APPLICABLE TO ITEM 19 <b>0 7   0 4   6 8</b>			
24. STATEMENT OF SERVICES RENDERED											
PRIMARY PURPOSE OF VISIT		NO VISITS		CHARGES		NO VISITS		CHARGES		25. POST-HOSPITAL PLAN	
A. Skilled Nursing Care				\$				\$		26. A TOTAL CHARGES	
B. Physical Therapy						1		10.00		27. B VERIFIED DEDUCTIBLE	
C. Speech Therapy										0	
D. Occupational Therapy										28. B VERIFIED COINSURANCE	
E. Medical Social Services										\$ 2.80	
F. Home Health Aide						1		4.00		29. C TOTAL CHARGES	
G. Other Visits (Specify)										14.00	
H. Total No. of Units of Service										30. D REIMBURSEMENT RATE	
I. Charge per unit of Service \$										90%	
J. TOTALS		\$				2		\$ 14.00		31. E TIMES D	
K. Other (Specify)										12.60	
L. TOTAL CHARGES		\$						\$ 14.00		32. F E LESS A	
M. AMOUNT PAID BY PATIENT		\$								12.60	
I certify that required physician's certification and recertifications are on file.										33. G REIMBURSEMENT AMT 80% OF F	
SIGNATURE OF HOME HEALTH AGENCY REPRESENTATIVE <b>/s/ Henry Daly</b>					DATE FORWARDED <b>0 7   0 6   6 8</b>		APPROVED BY <b>/s/ Thomas Sidas</b>		DATE APPROVED <b>0 7   1 6   6 8</b>		
FORM SSA-1487 (4-66)    HOME HEALTH AGENCY COPY											

## Example X

### X. INITIAL BILLING—PART A—EQUIPMENT FURNISHED AS HOME HEALTH SERVICE

This is the initial Part A bill following the final Part B bill in Example IX. The agency submitted a start of care notice.

A Part A plan was established July 20, 1968, and care started July 21, 1968.

The home health agency, in addition to visits, is now

furnishing a wheelchair to the patient. This is billed for in Item 21K.

Since services are now being furnished under a new home health plan, a new request for payment is required. The patient's signature has been obtained on the agency's record.

DEPARTMENT OF HEALTH, EDUCATION AND WELFARE SOCIAL SECURITY ADMINISTRATION <b>HOME HEALTH AGENCY REPORT AND BILLING</b> HOSPITAL AND MEDICAL INSURANCE BENEFITS—SOCIAL SECURITY ACT										Form Approved Budget Bureau No. No. 72-R736	
1 PATIENT'S LAST NAME <b>Doe</b>			2 FIRST NAME <b>John</b>			3 MI <b>H</b>		4 HEALTH INSURANCE CLAIM NUMBER <b>000-00-0000 A</b>			
5 PATIENT'S ADDRESS (Street number, City, State, Zip Code) <b>6401 Security Blvd., Baltimore, Md. 21235</b>						6 DATE OF BIRTH <b>09   09   92</b>		7 SEX <input checked="" type="checkbox"/> M <input type="checkbox"/> F			
8 HOME HEALTH AGENCY NAME AND ADDRESS <b>Neighborhood Nurse Association 425 East 165th, West Baltimore, Md. 21207</b>						9 PROVIDER NO. <b>000 000</b>		10 NAME AND ADDRESS OF ATTENDING PHYSICIAN <b>Harold Burns, M.D. 716 West 65 Street Baltimore, Md. 21209</b>			
11 DATE CARE STARTED <b>07   21   68</b>						12 NAME AND ADDRESS OF INSTITUTION, IF ANY, CARING FOR CONDITION LATER REQUIRING HOME HEALTH SERVICES <b>XYZ Hospital Bruce Street Baltimore, Md. 21209</b>			13 VERIFIED DATES OF STAY IN ITEM 11 FROM <b>07   04   68</b> TO <b>07   08   68</b>		
14 PAYMENT SOURCE FOR CHARGES TO PATIENT A <input type="checkbox"/> SELF OR FAMILY B <input type="checkbox"/> PRIVATE INSURANCE C <input type="checkbox"/> BLUE CROSS D <input type="checkbox"/> BLUE SHIELD E <input checked="" type="checkbox"/> PUBLIC AGENCY (Give name) F <input type="checkbox"/> EMPLOYER OR UNION G <input type="checkbox"/> OTHER (Explain)						15 Department of Welfare 702 Main St. Baltimore, Maryland 21209			16 Case No. <b>66464</b>		
17 PATIENT'S CERTIFICATION: AUTHORIZATION TO RELEASE INFORMATION AND PAYMENT REQUEST: I certify that the information given by me in applying for payment under Title XVIII of the Social Security Act is correct. I authorize release of all records required to act on this request. I request that payment of authorized benefits be made in my behalf.											
SIGNATURE (Patient or authorized representative) (Signature by mark must be witnessed)									DATE		
Patient request for payment on file									7/20/68		
18 DIAGNOSES <b>Cerebral Vascular Accident</b>						19 EMPLOYMENT RELATED A <input type="checkbox"/> YES B <input checked="" type="checkbox"/> NO (If yes, give name and address of employer.)		20 LEAVE BLANK			
21 STATEMENT COVERS PERIOD FROM <b>07   21   68</b> TO <b>07   31   68</b>		22 DATE OF FIRST VISIT		23 DATE OF LAST VISIT		24 PATIENT <input type="checkbox"/> DISCHARGED <input type="checkbox"/> DIED <input checked="" type="checkbox"/> STILL RECEIVES SERVICES <input type="checkbox"/> VISITS EXHAUSTED		25 DATE APPLICABLE TO ITEM 19			
26 STATEMENT OF SERVICES RENDERED				27 POST-HOSPITAL PLAN				28 MEDICAL PLAN			
PRIMARY PURPOSE OF VISIT				NO VISITS		CHARGES		NO VISITS		CHARGES	
A. Skilled Nursing Care				2		\$ 20.00				\$	
B. Physical Therapy											
C. Speech Therapy				4		40.00					
D. Occupational Therapy											
E. Medical Social Services											
F. Home Health Aide											
G. Other Visits (Specify)											
H. Total No. of Units of Service											
I. Charge per unit of Service \$											
J. TOTALS				6		\$ 60.00				\$	
K. Other (Specify)											
Wheel chair						10.00					
L. TOTAL CHARGES						\$ 70.00				\$	
M. AMOUNT PAID BY PATIENT											
I certify that required physician's certification and recertifications are on file.											
SIGNATURE OF HOME HEALTH AGENCY REPRESENTATIVE						DATE FORWARDED		APPROVED BY		DATE APPROVED	
/s/ Henry Daly						08   02   68		/s/ Thomas Sides		08   12   68	
FORM SSA-1487 (4-66) <span style="margin-left: 50px;">HOME HEALTH AGENCY COPY</span>											

## Example XI

### XI. FINAL BILLING—PART A—PHYSICIAN TERMINATES PLAN—EQUIPMENT STILL NEEDED

On March 9, 1969, the patient's physician decides that visits are no longer necessary. However, the wheelchair will still be required.

The home health agency will rent the patient the wheelchair after March 9, 1969.

This example shows the last Part A billing form for services to March 9, 1969.

DEPARTMENT OF HEALTH, EDUCATION AND WELFARE SOCIAL SECURITY ADMINISTRATION <b>HOME HEALTH AGENCY REPORT AND BILLING</b> HOSPITAL AND MEDICAL INSURANCE BENEFITS - SOCIAL SECURITY ACT										Form Approved Budget Bureau No. No. 72-8738																																																																																																																
1. PATIENT'S LAST NAME <b>Doa</b>			2. FIRST NAME <b>John</b>		3. MI <b>H</b>		4. HEALTH INSURANCE CLAIM NUMBER <b>000-00-0000 A</b>			5. SEX <input checked="" type="checkbox"/> M <input type="checkbox"/> F																																																																																																																
6. PATIENT'S ADDRESS (Street number, City, State, Zip Code) <b>6401 Security Blvd., Baltimore, Md. 21235</b>							7. DATE OF BIRTH		8. DATE OF BIRTH																																																																																																																	
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12. MEDICAL RECORD NO.					13. DATE CARE STARTED <b>07 21 68</b>					14. NAME AND ADDRESS OF INSTITUTION, IF ANY, CARING FOR CONDITION LATER REQUIRING HOME HEALTH SERVICES																																																																																																																
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17. PAYMENT SOURCE FOR CHARGES TO PATIENT A <input type="checkbox"/> SELF OR FAMILY C <input type="checkbox"/> BLUE CROSS E <input type="checkbox"/> PUBLIC AGENCY B <input type="checkbox"/> PRIVATE INSURANCE D <input type="checkbox"/> EMPLOYER OR UNION F <input type="checkbox"/> OTHER (Explain)																																																																																																																										
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24. STATEMENT COVERS PERIOD FROM TO <b>03 01 69 03 09 69</b>			25. DATE OF FIRST VISIT			26. DATE OF LAST VISIT			27. PATIENT <input checked="" type="checkbox"/> DISCHARGED <input type="checkbox"/> STILL RECEIVES SERVICES <input type="checkbox"/> VISITS EXHAUSTED <input type="checkbox"/> DIED																																																																																																																	
28. DATE APPLICABLE TO ITEM 18 <b>03 09 69</b>																																																																																																																										
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FORM SSA-1487 (4-68) HOME HEALTH AGENCY COPY																																																																																																																										



## EXAMPLE XII

## XII. BILLING FOR RENTAL OF EQUIPMENT - PART B

On March 10, 1969, the rental of the wheelchair takes effect. The rental of durable medical equipment is reimbursable on a cost basis under Part B. This example shows the billing form for the period March 10, 1969, through March 31, 1969.

The agency prepares an SSA-1483 since the patient is no longer under a plan of treatment.

The agency does not complete items 24 or 25.

On receipt of the bill the intermediary queries to SSA central records for the patient's 1969 deductible status. The reply indicates that \$16 of the deductible remains to be met.

The patient owes \$16 toward the Part B deductible. \$16 is subtracted from the total charges of \$21 leaving a total of \$5. Twenty percent of \$5 is \$1 which the patient owes as coinsurance. \$16 is entered in Item 24 B and \$1 in 24 C.

The \$21 total charges are multiplied by the 90% reimbursement rate leaving a total of \$18.90. The \$16 deductible is subtracted leaving a total of \$2.90. Eighty percent of this amount or \$2.32 is entered in Item 25 in the "Provider" block. 0 is entered in "Patient" block.

**PROVIDER BILLING FOR MEDICAL AND OTHER HEALTH SERVICES**  
**MEDICAL INSURANCE BENEFITS - SOCIAL SECURITY ACT**

Form Approved  
 Budget Bureau  
 No. 72-R0738

1. Patient's last name Doe		First name John	MI H	2. Health insurance claim number 000-00-0000A	
3. Patient's address (Street number, City, State, ZIP Code) 6401 Security Blvd., Baltimore, Md. 21235				4. Date of birth 09/09/99	5. Sex <input checked="" type="checkbox"/> M <input type="checkbox"/> F
6. Provider name and address, (City and State) Visiting Nurse Association Baltimore, Md. 21201		7. Provider number 000000		9. Type of service A. <input type="checkbox"/> Inpatient C. <input checked="" type="checkbox"/> Other (Specify) Home Health Agency B. <input type="checkbox"/> Outpatient	
		8. Medical record number			

If you have other health insurance or if your State Medical Assistance Agency will pay part of your medical expenses and you want information about this claim released to them upon their request complete items 10 and 11.

10. Insuring organization or State agency name and address		11. Policy or medical assistance number
12. Patient's Certification, Authorization to Release Information, and Payment Request. I certify that the information given by me in applying for payment under Title XVIII of the Social Security Act is correct. I authorize any holder of medical or other information about me to release to the Social Security Administration or its intermediaries or carriers any information needed for this or a related medicare claim. I request that payment of authorized benefits be made on my behalf.		

<input checked="" type="checkbox"/> Contained in provider's record	Signature (Patient or authorized representative) (Signature by mark must be witnessed)	Date
13. Nature of illness or injury Cerebral Vascular Accident		<input type="checkbox"/> Check here if illness or injury was connected with employment Do not use this space
14. Surgical procedures		

15. Statement of services	Covered Charges	16. Statement Covers Period	First service	Last service	
A. Clinic visit ( )			03/10/69	03/31/69	
B. Emergency room ( )		17. Blood Information	A. Pints furnished	B. Pints replaced	
C. Laboratory			C. Pints	D. Charge per pint	E. Patient paid for deductible
D. Radiology		18. Professional component (hospital inpatients)		19. Other professional component	
E. Pharmacy		A. Pathology			
F. Blood		20. Date benefits exhausted or HH plan terminated 03/09/69		21. Patient paid (Excluding 17E) None	
G. Ambulance		22. I certify that the required physician's certification is on file. S. I. Sides		23. Date forwarded 04/05/69	
H. Physical therapy		FOR INTERMEDIARY USE ONLY			
I. Other (Specify)		24. Verified Patient Liability			
Rental of Wheel Chair	21 00*	A. Blood deductible	B. Cash deductible \$16.00	C. Coinsurance \$1.00	
J. TOTAL	21 00	25. Payment Distribution Provider \$2.32 Patient 0		26. Date approved 04/19/69	

Remarks:

\*Summit Rental Agency  
 25 Paca St.  
 Baltimore, Md. 21202





Items 10 and 11. Complementary Coverage Information.--If information about the claim is to be sent to a complementary insurer at the patient's request, and the agency does not object, the name and address of the organization or agency should be shown. The identifying number will be shown in item 11.

Item 12. Patient's Certification.--Have the patient or his authorized representative read the statement on the form or on the agency's record if it uses the alternate signature procedure. (See §§ 405ff.)

If the agency obtains the signature on its own form, check the block marked "Contained in provider's record." If the signature is obtained on form SSA-1483, it is sufficient if it is legible on the original only. A signature is required with each billing. If the agency obtains a signature on its own record, it will remain effective as long as the particular service is being received from the same agency according to the physician's order.

If the patient cannot sign his name because of his physical or mental condition, another person may sign on his behalf, e.g., John J. Jones by Jack A. Smith. In certain situations, a home health agency representative may sign on behalf of the patient. (See § 235.1 for who may file a payment request.) Briefly explain why the patient did not sign the form himself and show the relationship of the signer to the patient. This explanation should be retained in the agency's file if the signature is obtained on the home health agency's own record. If the signature is on form SSA-1483, the explanation should accompany or be included on the billing form. The statement should be read to the patient who signs by mark.

A signature by mark should be witnessed by a person who knows the patient. Enter the name and address of any person witnessing a signature by mark.

If it is impractical to obtain the patient's signature because the agency does not make a visit to his home (e.g., the physician certifies that the patient needs a certain item of durable medical equipment but no visits are certified), the agency may furnish the equipment and need not obtain the patient's signature. An agency representative should sign on behalf of the patient and write in this item "Patient not visited."

Item 13. Nature of Illness or Injury.--An entry must be made only on bills where the patient's health insurance number ends in "0"- "4" - "5" or "8."

When necessary, enter the nature of illness or injury as furnished by the attending physician. Acceptable medical terminology should be used, such as "Current Medical Terminology", "Standard Nomenclature of Diseases and Operations," and "International Classification of Diseases Adapted."

If the condition was employment related, check the block and show the name and address of the employer, if known. Where the agency knows that a workmen's compensation claim has been made, it should insert or attach a statement identifying the carrier, if any, handling the workmen's compensation claim, and give any available details about the claim. (See §§ 250ff for additional information.)

Item 14. Surgical Procedures.--No entry should be made in this item.

Item 15. Statement of Services Rendered.--Enter the covered Part B charges during the billing period which do not constitute reimbursable home health services. If the service was furnished under arrangements with suppliers outside the agency, but is being billed by the agency, enter an asterisk by the type of service furnished and cross-refer this to the name and address of the supplier in remarks.

H. Physical therapy		
I. Other (Specify)	15	00*
J. TOTAL	15	00

Remarks:

\* Doran's Rental Shop  
2401 Birge  
Baltimore, Md. 21000

Home Health Agencies should make no entry in A. Clinic Visit, B. Emergency Room, C. Laboratory, D. Radiology, E. Pharmacy, F. Blood.

Durable medical equipment furnished should be entered under "I." Indicate whether it is rented or purchased. Show the full purchase price if the equipment is purchased.

Show total covered charges on line J.

Item 16. Statement Covers Period.--Enter the dates of the first and last service furnished during the billing period. Do not bill for an inclusive period spanning two calendar years, since the deductible applies to the charges incurred in each year independently. Usually the date of the first service should be later than the date of the last service on the preceding bill.

Item 17. Blood Information.--Home Health Agencies should make no entry in item 17.

Item 18. Professional Component (Hospital Inpatients).--Home Health Agencies should make no entry in this item.

Item 19. Other Professional Component.--Home Health Agencies should make no entry in this item.

Item 20. Date Benefits Exhausted or Home Health Plan Terminated.--Enter a date only when home health visits are exhausted or the physician's plan of treatment is terminated.

Item 21. Patient Paid.--Enter the amount, if any, paid by the patient. Do not include any amount paid by a separate billing for physicians' services.

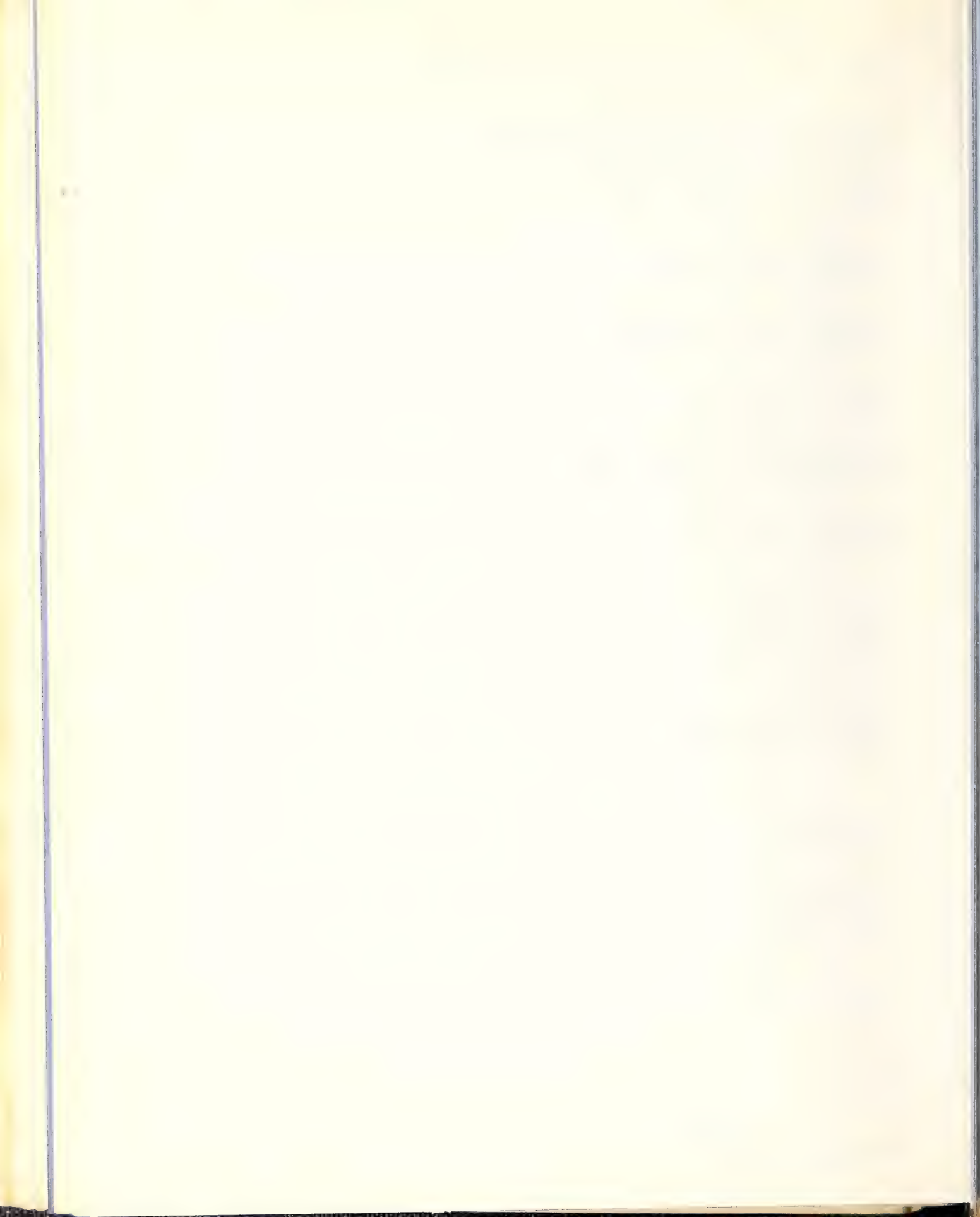
Item 22. Signature of Agency Representative.--Before the billing is forwarded to the intermediary, an agency representative should assure himself that the physician's certification as to medical necessity is on file. The representative should sign his name; a stamped signature is acceptable.

Item 23. Date Forwarded.--Enter the date on which the form was forwarded to the intermediary.

The balance of the form is for the use of the intermediary in computing the payments to be made to the agency and/or patient.

The Home Health Agency should make no entry in items 24, 25, and 26.





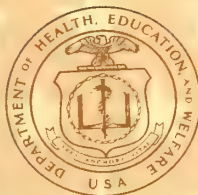






HEALTH  
INSURANCE  
FOR THE AGED

EXTENDED  
CARE FACILITY  
MANUAL



U.S. DEPARTMENT OF  
HEALTH, EDUCATION, AND WELFARE  
SOCIAL SECURITY ADMINISTRATION

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# Health Insurance for the Aged

## EXTENDED CARE FACILITY MANUAL

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### USING THE EXTENDED CARE FACILITY MANUAL

#### *Use It for Reference*

The manual covers not only routine information for your day-to-day operations but tries to anticipate infrequent situations that could occur. It has been indexed for ease of reference.

#### *Keep It Available*

Pages are punched for any standard-size three-ring binder. Keep it handy and ask for as many extra copies as you need.

#### *Keep It Up-to-Date*

Insert or replacement pages and supplements for additions and revisions will be furnished through your intermediary. Maintain a control on all manuals to assure immediate updating.



## FOREWORD

This manual is designed for use by extended care facilities which will be billing for services furnished under the provisions of the Health Insurance for the Aged Act of 1965. It contains informational and procedural material the facility will need to assist in prompt and efficient payment of claims and to answer questions which patients may ask about the program. This issuance should help to assure that the law is uniformly applied nationally without regard to where covered services are furnished. The facility's intermediary will issue any necessary additional instructions on matters which concern the relationship between facilities and intermediaries.

The manual does not have the effect of regulations, but a careful effort has been made to insure that the provisions of the law and proposed regulations are accurately reflected.

The procedures described in this manual have been devised to satisfy the administrative needs of the program with a minimum of inconvenience to beneficiaries, and to extended care facilities and their intermediaries. We believe that the vast majority of claims will lend themselves to simple, routine handling.

The manual is designed to accommodate new pages as further interpretations of the law and changes in procedures are made. Accordingly, supplements, and revised sections, pages or chapters will be issued as the need presents itself.

Your intermediary will answer any questions you may have about policies and procedures in the program. Extended care facilities dealing directly with the Social Security Administration may direct questions to the servicing social security district office for reply or refer them to the Bureau of Health Insurance Regional Representative.

ARTHUR E. HESS  
*Director, Bureau of Health Insurance*

## Chapter I

### GENERAL INFORMATION ABOUT THE PROGRAM

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## Chapter I

### GENERAL INFORMATION ABOUT THE PROGRAM

#### 100. INTRODUCTION

The Health Insurance for the Aged Act, Title XVIII of the Social Security Act, has made available to nearly every American 65 years of age and older a broad program of health insurance designed to assist the Nation's elderly to meet hospital, medical, and other health costs. The program includes two related health insurance programs—hospital insurance (Part A of the law) and voluntary supplementary medical insurance (Part B of the law).

The conduct of the program has been delegated by the Secretary of Health, Education, and Welfare, to the Commissioner of Social Security. Congress has provided substantial administrative roles for the States and for voluntary insurance organizations in recognition of their experience in the health care and insurance fields.

The law specifically prohibits the Federal Government from exercising supervision or control over the practice of medicine, the manner in which medical services are provided, and the administration or operation of medical facilities. The patient is free to choose any qualified institution, agency, or person offering him services. The responsibility for his treatment and the control of his care remains with his physician and the hospital, facility, or agency furnishing him services. The individual may keep or obtain any other health insurance he desires.

#### 102. DISCRIMINATION PROHIBITED

Participating providers of services under the hospital insurance program, i.e., hospitals, extended care facilities, and home health agencies, must comply with the requirements of Title VI of the Civil Rights Act of 1964. Under the provisions of that Act a participating extended care facility is prohibited from making a distinction on the ground of race, color, or national origin in the admission and treatment of patients; the accommodations provided; the use of equipment and other facilities; and the assignment of personnel to provide services.

The Department of Health, Education, and Welfare

is responsible for investigating complaints of noncompliance.

#### 104. DISCLOSURE OF INFORMATION

Records and information acquired in the administration of the Social Security Act are confidential and may be disclosed only under the conditions prescribed in regulations or on the express authorization of the Commissioner of Social Security. The regulations of the Department of Health, Education, and Welfare regarding the confidentiality of records and information apply not only to governmental agencies, but also to public and private agencies participating in the administration of the program as well as those institutions, facilities, agencies, and persons providing services, and those furnishing services under arrangements with a provider of services.

However, the information in the provider's medical records of a patient (except for information therein furnished specifically for purposes of a claim under the program—such as the individual's health insurance claim number, the fact of his entitlement to health insurance benefits, and medical and other information obtained from the Social Security Administration or an intermediary, etc.) is not subject to these rules and regulations even though the patient receives benefits under this program. These records, however, may be subject to State or local laws or extended care facility rules governing disclosure, and are subject to the requirement of confidentiality in the "Conditions of Participation for Extended Care Facilities."

Disclosure by a provider of records or information acquired under the health insurance program is permitted only when the record or information is to be used in connection with a claim for health insurance benefits and such disclosure is necessary for the proper performance of the duties of any officer or employee of the Department of Health, Education, and Welfare, or for the proper performance of the duties in administration of the health insurance program of any officer or employee of a public or private agency or organization which has entered into an agreement with the Secretary of Health,

Education, and Welfare to perform certain administrative functions under the program.

Program information furnished by an extended care facility to a State agency certifying providers in the health insurance program may, with the approval of the Department of Health, Education, and Welfare, be disclosed by the State agency to the State licensing authority if the information relates to the provider's compliance or noncompliance with the licensure requirements.

Health insurance information may not be disclosed by extended care facilities, other than as described above, except under the conditions prescribed by regulations and in accordance with procedures established by the Social Security Administration. The Administration has issued guidelines to be used by intermediaries in making arrangements with State welfare agencies for the release of billing information to the welfare agencies in those cases in which payment of the cost of extended care services is to be made both under the health insurance program and the State welfare program. Where State agencies have entered into agreements with health insurance intermediaries, implementation of the procedures will depend upon the State welfare agencies making the necessary arrangements with the facility involved.

## **110. HOSPITAL INSURANCE—A BRIEF DESCRIPTION**

This is the basic part of the health insurance program and is designed to help patients defray the expenses incurred by hospitalization and related care. In addition to inpatient hospital benefits, hospital insurance covers outpatient hospital diagnostic services, posthospital care in extended care facilities, and in the patient's home by home health agencies. In providing these benefits, recognition was given to the need for continued treatment after hospitalization and the need to encourage the use of less expensive substitutes for inpatient hospital care. Program payment for services rendered to beneficiaries by providers (i.e., hospitals, extended care facilities, and home health agencies) may be made only to the provider, and is based on the reasonable cost of the covered services furnished.

**110.1 Posthospital Extended Care Services.**—Coverage of extended care services is provided under hospital insurance. The definition of the extended care facility, requirements for coverage, a description of extended care benefits, and the applicable coinsurance, limitations and exclusions are fully treated in Chapter II.

**110.2 Inpatient Hospital Services.**—The items

and services covered include: bed and board in a semi-private (2 to 4 beds) accommodation, unless a private room is medically necessary; nursing and other related services; use of hospital facilities and medical social services ordinarily furnished by the hospital for the care and treatment of inpatients; drugs, biologicals, supplies, appliances, and equipment for use in the hospital, which are ordinarily furnished by the hospital; diagnostic or other therapeutic items or services furnished by the hospital or by others under arrangements made by the hospital; services by interns or residents-in-training if they are under a teaching program approved by the American Medical Association, American Osteopathic Association, or American Dental Association; and cost of whole blood after the first 3 pints in a spell of illness and all costs of administering the blood including the provider's costs of administering the first 3 pints.

The patient is entitled to payment on his behalf for up to 90 days of inpatient hospital services in each spell of illness. There is an inpatient hospital deductible of \$40 in each spell of illness and a coinsurance amount of \$10 per day after the 60th day and through the 90th day. The deductible and coinsurance amounts are subject to change on January 1, 1969, and on the first day of each year thereafter.

Inpatient tuberculosis hospital services are covered if the services furnished to the individual are services which can reasonably be expected to improve his condition or render it noncommunicable. Inpatient psychiatric hospital services are covered if the services furnished to the patient are furnished when he is receiving intensive treatment, or are necessary for medically required inpatient diagnostic study. Where an individual is in a qualified tuberculosis or psychiatric hospital on the first day of the first month for which he is entitled to hospital insurance benefits, the days on which he was an inpatient of such a hospital in the 90-day period immediately before his first day of entitlement must be counted in determining the 90-day limit on inpatient hospital services in his first spell of illness. In addition, there is a lifetime limitation of 190 days for payment for inpatient psychiatric hospital services. A period spent in a psychiatric hospital prior to entitlement, however, does not count against the 190 days.

**110.3 Outpatient Hospital Diagnostic Services.**—Outpatient hospital diagnostic services covered under hospital insurance include—

A. diagnostic tests and related services to the extent that they would not be excluded if performed on an inpatient basis;



B. drugs and biologicals necessary for diagnostic study;

C. the services rendered in connection with a diagnostic study by an intern or resident-in-training under an approved teaching program; and

D. other services and supplies if customarily furnished to outpatients for purposes of diagnostic study.

Benefits are payable on the basis of a diagnostic study period, which is a period of 20 consecutive days beginning with the first day, not included in a previous diagnostic study, on which the patient receives outpatient diagnostic services.

The **deductible** for outpatient hospital diagnostic services during each diagnostic study is one-half the inpatient hospital deductible, or \$20. This deductible amount counts as an incurred expense for individuals with supplementary medical insurance coverage. After satisfying the \$20 deductible, the patient is responsible for a coinsurance amount equal to 20 percent of the reasonable charges, not in excess of the amount customarily charged, for the outpatient hospital diagnostic services rendered during the diagnostic study.

**110.4 Posthospital Home Health Services.**—Home health services under hospital insurance include up to 100 home health visits after the beginning of one spell of illness and before the beginning of the next furnished a patient within one year of his most recent discharge from a hospital of which he was an inpatient for at least 3 consecutive calendar days. If, after his hospitalization, he had a covered stay in an extended care facility, the 1 year during which the patient may receive home health services begins with the discharge from the extended care facility. A plan of treatment must be established within 14 days after the hospital or extended care facility discharge. Home health services are provided also under supplementary medical insurance. (For the latter, see § 115.1.)

The patient receiving posthospital home health services must be under the care of a physician who must establish and periodically review the plan for his patient's care. To be covered the services must be required by a condition for which the patient required inpatient hospital services or extended care services and the patient must be confined to his home. Discharge from the period of hospitalization required for home health services must occur after June 30, 1966, or on or after the first day of the month in which the patient attains age 65, whichever is later.

Home health services are services provided by a home health agency or by others under arrangements with such an agency. A home health agency is a public or private organization which is primarily engaged

in providing skilled nursing and other therapeutic services. Where applicable, the agency must be licensed under State or local law, or be approved by the State or local licensing agency as meeting the licensing standards. Examples of home health agencies are visiting nurse associations, official health agencies, and hospital-based home care programs. To participate in the health insurance program a home health agency must meet certain other requirements included in the law as well as health and safety conditions prescribed by the Secretary of Health, Education, and Welfare. It may not qualify under hospital insurance, however, if it is primarily engaged in the treatment of mental diseases.

These services are usually furnished on a visiting basis in a place of residence used as the individual's home. However, outpatient services in a hospital, extended care facility, or rehabilitation center are covered home health services, if arranged for by a home health agency, when equipment is required that cannot be made available in the patient's home.

Covered home health services include part-time nursing care by or under the supervision of a registered professional nurse; physical, occupational, or speech therapy; medical social services; certain services of a home health aide; medical supplies (other than drugs and biologicals); and the use of medical appliances. The costs of housekeepers, food service arrangements, and transportation to outpatient facilities are excluded as home health services.

The services of an intern or resident-in-training are covered if the agency and hospital are affiliated or under common control and the agency bills for the services.

## **115. SUPPLEMENTARY MEDICAL INSURANCE—A BRIEF DESCRIPTION**

**115.1 Benefits.**—The voluntary medical insurance plan is designed to supplement the basic hospital insurance coverage. It provides coverage effective July 1, 1966, for (a) home health visits and (b) medical and other health services.

A. Medical insurance covers home health services for up to 100 visits during the calendar year (in addition to the visits covered under hospital insurance) but without the requirement of prior inpatient hospital care.

B. Medical and other health services include:

1. Physicians' services (see definition of "physician" below) including surgery, consultation, and home, office, and institutional calls.

Regardless of the actual expenses for physician serv-



ices incurred in the treatment of mental, psychoneurotic, or personality disorders of persons who are not inpatients of hospitals, the amount of such expenses that can be counted in a calendar year is limited to the lesser of \$312.50 or 62.5 percent of the actual expenses.

**Physician** means a doctor of medicine or osteopathy (including osteopathic practitioner) legally authorized to practice by a State in which he performs the function or action. A doctor of dental surgery or dental medicine having State authorization to practice is also defined as a physician but only for surgery related to the jaw or any structure contiguous to the jaw, or the reduction of a fracture of the jaw or any facial bone. (These services must be services that could be performed by either a qualified physician or dentist; routine dental care is not included.) The services performed by physicians within these definitions are subject to any limitations imposed by the State on the scope of practice.

2. Services and supplies (including drugs and biologicals which cannot be self-administered) incident to physicians' professional services and of kinds commonly furnished by a physician in his office and which are commonly rendered without charge or included in his bill, and hospital services incident to physicians' services rendered to outpatients.

3. Diagnostic X-ray, laboratory, and other diagnostic tests unless furnished as outpatient hospital services to patients having Part A coverage.

4. X-ray, radium, and radioactive isotope therapy (including material and services of technicians).

5. Surgical dressings, and splints, casts, and other devices used for reduction of fractures and dislocations.

6. Rental (for use in the patient's residence, including an institution used as his home) of such durable medical equipment as iron lungs, oxygen tents, wheelchairs, and special beds.

7. Ambulance service, where the use of other transportation is contraindicated by the patient's condition.

8. Prosthetic devices (other than dental) replacing all or part of an internal body organ, including replacement of such devices.

9. Leg, arm, back, and neck braces, and artificial legs, arms, and eyes, including replacements if required because of a change in physical condition.

**115.2 Basis for Payment.**—Payment, based on **reasonable charges**, may be made to or on behalf of individuals covered by medical insurance for services of physicians and other nonprovider services furnished under the plan. In determining the reasonableness of charges, the carrier takes into consideration the customary charges of the physician (or other person

rendering the service) as well as the prevailing charges in the locality generally made for similar services. A charge is not reasonable if it is higher than the charge applicable for a comparable service and under comparable circumstances to the intermediary's own policyholders or subscribers.

Payment for services covered by medical insurance and rendered by a hospital, extended care facility, or home health agency, or under arrangements made by such provider, is based on the reasonable cost of the services and is made only to the provider of services. This is the same basis for reimbursement as under the hospital insurance plan and accords with the provider's undertaking in the participation agreement to accept reasonable cost as full payment for services rendered.

**115.3 Deductible and Coinsurance.**—In each calendar year a deductible of \$50 must be satisfied before payment may be made under the supplementary medical insurance plan. Expenses applied toward the deductible in the last 3 months of a year may also be applied toward the deductible in the following year. After the deductible has been satisfied, payment by the supplementary medical insurance program will be made for 80 percent of the reasonable charge for physicians' and suppliers' services or reasonable cost of provider services.

## **120. ENTITLEMENT TO HOSPITAL INSURANCE**

A. An individual is **automatically** entitled to hospital insurance beginning with the first day of the month he attains age 65 if he has applied for and been determined to be entitled to monthly social security benefits (although he may not actually be receiving benefit payments, e.g., he has not retired). Automatic entitlement also extends to qualified beneficiaries under the Railroad Retirement Act. (For social security purposes, a person attains age 65 on the day before his 65th birthday.) Example: If birth date is August 1, attainment date is July 31, and health insurance entitlement date is July 1.

A social security applicant who applies for monthly benefits after the month he reaches age 65 is entitled to retroactive hospital insurance benefits beginning with the first month in which he had attained age 65 and met all the requirements for monthly benefits, but not for more than 12 months before the month in which he filed his application.

Entitlement to hospital insurance benefits ends with the month the individual ceases to be entitled to social security monthly benefits or ceases to be a qualified railroad beneficiary (for example, a woman whose wife's benefits are terminated by divorce). A person

who ceases to be a social security or railroad retirement beneficiary but who meets the requirements of the special transitional provision described below may reinstate his hospital insurance by filing a proper application under the transitional provision.

Hospital insurance coverage continues for the month of death, although no monthly cash benefits are payable for that month.

B. A special **transitional** provision in the law permits persons 65 years of age and over, who cannot qualify for monthly social security or railroad retirement benefits, to obtain hospital insurance upon filing application. Such an individual must be a resident of the United States and either a citizen, or an alien lawfully admitted for permanent residence who has resided in the United States continuously for 5 years. He may not be an active or retired Federal employee (or spouse of one) who is or could have been covered by the Federal Employees Health Benefit Act of 1959. He may not be a member of a communist organization nor have been convicted of a crime against the security of the United States.

For coverage under the transitional provision, a person attaining age 65 after 1967 must have three quarters of coverage for each year elapsing between 1965 and the year in which he attains age 65.

Hospital insurance under the transitional provision can also be retroactive for as many as 12 months before the month of application, provided the individual meets all the other requirements during the period of retroactivity.

## **122. ENTITLEMENT TO SUPPLEMENTARY MEDICAL INSURANCE**

A. **Enrollment.**—To obtain supplementary medical insurance coverage an individual must voluntarily enroll in the plan and pay the required premiums. He may enroll if he is entitled to hospital insurance benefits or, if he is age 65, a resident of the United States, and either a citizen or an alien admitted for permanent residence. Active or retired Federal employees and their spouses are eligible to enroll whether or not covered under the Federal Employees Health Benefit Act. (For social security purposes an individual attains age 65 on the day before his 65th birthday.)

By agreement States may enroll in the supplementary medical insurance plan eligible individuals who are receiving money payments under certain public assistance programs. Such persons who are entitled to monthly social security or railroad retirement benefits may be included at the option of the State.

B. **Enrollment Periods.**—Enrollment is possible only during specified enrollment periods.

1. During the **initial general enrollment period** an opportunity to enroll was afforded to all eligible persons age 65 and over before March 1, 1966. This enrollment period ended May 31, 1966. (An eligible individual who for good cause failed to enroll before June 1, 1966, could have enrolled before October 1, 1966.)

2. For persons first eligible on or after March 1, 1966, the **initial enrollment period** is 7 months. It begins 3 calendar months before and ends 3 calendar months after the month in which the individual first meets all enrollment requirements.

3. **General enrollment periods** occur October 1 through December 31 of each odd-numbered year, beginning with 1967. Those who failed to enroll during their initial enrollment periods and those whose enrollment has terminated may enroll in these periods.

4. **States which desire to enroll eligible individuals receiving public assistance** must request coverage before January 1968, and enter into an agreement with the Government.

An individual who fails to enroll for medical insurance within the 3-year period after the close of his initial enrollment period may not enroll thereafter.

An individual whose enrollment has terminated may re-enroll only once—in a general enrollment period which begins within 3 years after the termination of his prior enrollment.

Payment may be made for covered services if the individual was enrolled at the time the services were furnished, even though at the time the request for payment is filed with the intermediary his enrollment had been terminated.

**122.1 Premiums.**—Initially, the premium is \$3 per month. The law permits the Secretary of Health, Education, and Welfare to adjust the premium amount in accordance with changes in medical and other costs. No change in the premium is permitted before 1968, and changes thereafter can be no oftener than every 2 years. To take into account the higher cost of insuring older individuals, premiums payable by a person who enrolls after the first enrollment period open to him, or who re-enrolls after his initial enrollment was terminated, are increased by 10 percent for each full 12 months during which he could have been but was not enrolled.

A grace period has been provided for payment of premiums. This period extends 2 calendar months after the month in which the premium is due.

Persons enrolled for medical insurance and receiving social security, railroad retirement, or civil service



retirement benefits (except those enrolled by the State as public assistance recipients) will have the premiums withheld from their monthly checks. The State pays the premiums for the public assistance recipients it enrolls.

Other enrollees must make premium payments directly to the Social Security Administration. Enrollees who make direct premium payment will generally be billed quarterly. However, organizations, employers, unions, etc., may under certain conditions pay premiums for their members as a group.

### **122.2 Beginning of Coverage**

A. Enrollment during the initial general enrollment period—coverage begins July 1, 1966. An individual who attained age 65 prior to March 1966, and who, on establishing good cause for failure to enroll timely, enrolled from June 1, 1966, through September 30, 1966, has coverage beginning the 1st day of the 6th month after the month in which he enrolled.

B. Enrollment during an entitled individual's initial enrollment period—coverage begins:

1. 1st day of the month in which the individual becomes age 65, if he enrolls **before** the month that he becomes age 65.

2. 1st day of the month following the month that he becomes age 65, if he enrolls **in** the month that he becomes age 65.

3. 1st day of the 2d month after the month of enrollment, if he enrolls in the month **after** he becomes age 65.

4. 1st day of the 3d month after the month of enrollment, if he enrolls **more than 1** month **after** the month in which he became age 65. (However, individuals who became age 65 in March 1966, and enrolled in May 1966, have coverage effective July 1, 1966.)

C. Enrollment during one of the general enrollment periods—coverage begins the following July 1st.

D. Enrollment by a State of its welfare recipients—coverage begins on the latest of the following but not later than January 1, 1968:

1. July 1, 1966;

2. 1st day of the 3d month after the month of the agreement with the State;

3. 1st day of the 1st month in which the individual is both eligible and a member of the group;

4. The date specified in the agreement.

### **122.3 End of Coverage**

A. An individual whose medical insurance premiums are being deducted may notify the Social Security Administration in writing during a general enrollment period that he no longer wants medical insurance. His

coverage period will be terminated with the close of the year in which his notice is submitted.

B. Enrollment under medical insurance is terminated because of nonpayment of premiums. Termination is effective with the end of the grace period provided for payment of premiums.

C. If an individual is enrolled under a Federal-State agreement, his coverage under the agreement ends on whichever of the following first occurs:

1. The end of the month in which he becomes ineligible (as determined by the State) for welfare money payment; or

2. The end of the month before the first month for which he becomes entitled to monthly social security or railroad retirement benefits, unless the State exercises its option to enroll its welfare recipients who are entitled to such benefits.

If an individual's coverage under a Federal-State enrollment agreement is terminated, his coverage continues without interruption subject to the applicable premium payment requirements.

A social security or railroad retirement beneficiary who was enrolled under a State agreement and thereafter ceases to be a public assistance recipient may terminate his enrollment during the 3-month period after the month he leaves the public assistance rolls.

D. An individual will have coverage through the month in which he dies.

## **130. FEDERAL GOVERNMENT ADMINISTRATION OF THE HEALTH INSURANCE PROGRAM**

The Department of Health, Education, and Welfare has been given overall responsibility for administration of the hospital insurance and voluntary supplementary medical insurance programs. Three major agencies of the Department—the Social Security Administration, Public Health Service, and Welfare Administration—are involved.

**130.1 The Social Security Administration** has the responsibility for policy formulation and the general management and operational aspects of the program. Briefly, these include: determination of the individual's entitlement to benefits and the nature and duration of services for which benefits may be paid; establishment, maintenance, and administration of agreements with State agencies, providers of services and intermediaries; in consultation with the Public Health Service and the Welfare Administration, the formulation of major policies regarding conditions of participation for providers; the development and maintenance of statistical research and actuarial pro-



grams; and the general fiscal management of the program. The Administration also makes determinations of reasonable costs and amounts to be paid to providers who have elected to deal directly with the Government.

**130.2 The Public Health Service** has the principal responsibility for the professional health aspects of the program. These include: professional consultation and recommendation to the Social Security Administration in development of health and safety, and other guidelines for determining whether providers of services meet the conditions for participation under the program; consultation and advice to State agencies concerning the application of standards for providers, and in the coordination of program activities with other health services and activities in the State; and activities necessary in studying the utilization of hospital and other medical care services under the program.

**130.3 The Welfare Administration** has the primary role in hospital and medical insurance program planning, coordination, and evaluation in matters that affect other federally aided assistance programs; in assisting State agencies to achieve a coordinated approach with other medical care plans under the Social Security Act; and in all aspects of program administration affecting public welfare agencies.

### 131. ADVISORY GROUPS

The law provides for the appointment of two non-governmental advisory groups to assist the Secretary.

**131.1 The Health Insurance Benefits Advisory Council**, consisting of persons outstanding in hospital, medical, and other health activities, and at least one representative of the general public, advises the Secretary on general policy in administering the program and in the formulation of regulations. The Secretary must consult with the Council in determining conditions of participation for providers of services in addition to the requirements specifically enumerated in the law.

**131.2 The National Medical Review Committee** is to be selected from people who are representative of professional organizations and associations in the field of medicine and other individuals who are outstanding in the field of medicine or related fields. At least one member will represent the general public and a majority of the committee are to be physicians. The committee studies the utilization of hospital and other medical services under the program and makes any recommendations to the Secretary and to Congress that it considers appropriate.

### 132. STATE AGENCIES

The States are accorded important administrative functions to the extent that each is willing and able to undertake them by agreement with the Secretary.

A. **Certifications** are made by State agencies to the Department of Health, Education, and Welfare indicating whether hospitals, extended care facilities, home health agencies, and independent laboratories meet and continue to meet their respective conditions of participation. This function is intended to be a natural adjunct to ongoing State activities, such as licensing of health facilities and other standard setting activities.

B. **Consultation** services are rendered by State agencies if their agreements provide for it. Consultation with hospitals, extended care facilities, and home health agencies that need and request assistance to meet the conditions of participation is an integral part of the certification process.

C. **Coordination** by the State relates its activities in the performance of its functions under the program to the various other programs in the State that have to do with payment for health care, quality of care, and distribution of health facilities. Coordination of such activities is designed to utilize existing State facilities and trained personnel effectively and economically and to prevent duplication of effort.

D. **State Agency as a Medical Insurance Intermediary.**—Where a State enters into an agreement with the Government to pay the medical insurance premium on behalf of its aged welfare recipients, as explained in § 122A of this chapter, the agreement may provide for a designated State agency to serve as an intermediary on behalf of its welfare recipients.

### 135. HOSPITAL INSURANCE INTERMEDIARIES

Under the hospital insurance plan, groups, or associations of providers, on behalf of their members, may nominate a national, State, or other public or private agency, or organization to serve as intermediary in the claims process. A member of an association is free, however, to receive payment from an approved intermediary other than its association's nominee, if agreeable to the Social Security Administration and to the intermediary selected. A provider may deal directly with the Social Security Administration.

The law permits the Administration to enter into an agreement with a nominated organization if it finds this to be consistent with effective and efficient administration of the hospital insurance program. The inter-

mediary makes payments to providers for covered items and services on the basis of reasonable cost determinations and assists in the application of safeguards against unnecessary utilization of covered services. The agreement may also call for furnishing consultative services to assist providers to establish and maintain necessary fiscal records and otherwise qualify as providers of services; serving as a center for communicating with providers; and making audits of provider records.

Generally speaking, the Social Security Administration will utilize the services of the hospital insurance intermediary in making payments for provider services under medical insurance.

### **137. MEDICAL INSURANCE CARRIERS**

The law requires the Secretary to enter into contracts which carriers selected to serve as intermediaries for the performance of specified administrative functions under the medical insurance program. The principal function of this intermediary is to determine whether physicians' charges are reasonable and to make payment. Section 132.D. of this chapter explains the conditions under which a State agency may act as a supplementary medical insurance intermediary.

### **140. FINANCING HOSPITAL INSURANCE PROGRAM**

The hospital insurance program is financed through separate payroll contributions paid by employees, employers, and self-employed persons. The proceeds are earmarked for the Federal Hospital Insurance Trust Fund to keep them separate from other social security contributions. The law permits their use only for the payment of hospital insurance benefits and administrative expenses. The cost of providing hospital insurance benefits to persons who are not social security or railroad retirement beneficiaries is met by appropriations to the Federal Hospital Insurance Trust Fund from general revenues.

### **142. FINANCING SUPPLEMENTARY MEDICAL INSURANCE PROGRAM**

The supplementary medical insurance plan is financed by the monthly premiums of those who enroll under the plan, matched by an equal contribution from general revenues. All premiums and Government contributions for this plan are placed in a separate fund known as the Federal Supplementary Medical Insurance Trust Fund. This fund is devoted exclusively to the payment of medical insurance benefits and administrative expenses.

## Chapter II

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## Chapter II

### COVERAGE OF EXTENDED CARE FACILITY SERVICES

#### Definitions

##### 201. EXTENDED CARE FACILITY DEFINED

An extended care facility is an institution (or a distinct part of an institution, see § 201.1), such as a skilled nursing home or rehabilitation center, which has a transfer agreement in effect with one or more participating hospitals (see § 201.2 for transfer agreements and § 205 for definition of participating hospital), and which:

- a. is primarily engaged in providing to inpatients skilled nursing care and related services for patients who require medical or nursing care, or rehabilitation services for the rehabilitation of injured, disabled, or sick persons,
- b. has policies (developed with the advice of and periodically reviewed by a professional group including one or more physicians and one or more registered professional nurses) to govern the skilled nursing care and related medical or other services it provides,
- c. has a physician, a registered professional nurse, or a medical staff responsible for the execution of such policies,
- d. has a requirement that the health care of every patient must be under the supervision of a physician,
- e. provides for having a physician available to furnish necessary medical care in cases of an emergency,
- f. maintains clinical records on all patients,
- g. provides 24-hour nursing service sufficient to meet nursing needs in accordance with the policies developed pursuant to (b) above, and has at least one registered professional nurse employed full time,
- h. provides appropriate methods and procedures for dispensing and administering drugs and biologicals,
- i. has in effect a utilization review plan,
- j. is licensed in accordance with State or local law, or is approved by the State or local licensing agency as meeting the licensing standards where State or applicable local law provides for the licensing of institutions of this nature, **and**
- k. is in substantial compliance with health and safety requirements established by regulation. (These

health and safety requirements are contained in the "Conditions of Participation for Extended Care Facilities.")

A **qualified** extended care facility is one which meets all the requirements in the above definition.

The term extended care facility does not include any institution which is primarily for the care and treatment of mental diseases or tuberculosis.

**201.1 A Distinct Part of an Institution as an Extended Care Facility.**—In order to qualify for participation in the program as an extended care facility, a distinct part of an institution must be physically separated from the rest of the institution, i.e., it must represent an entire, physically identifiable unit consisting of all the beds within that unit such as a separate building, floor, wing, or ward. Although it is required that the distinct part be identifiable as a separate unit within the institution, it need not necessarily be confined to a single location within the institution's physical plant. The distinct part may, for example, consist of several floors or wards which are scattered throughout several different buildings within the institutional complex. In each case, however, the patients of the distinct part would have to be located in units which are physically separate from those units housing all other patients of the institution. Various beds scattered throughout the institution would not comprise a distinct part for purposes of being certified as an extended care facility.

**201.2 Transfer Agreements.**—To participate in the program an extended care facility must have a written transfer agreement with one or more participating hospitals (see § 205) providing for the transfer of patients between the hospital and the facility, and for the interchange of medical and other information. If an otherwise qualified extended care facility has attempted in good faith, but without success, to enter into a transfer agreement, this requirement may be waived by the State agency. (See XIV of the "Conditions of Participation for Extended Care Facilities" (HIM-3) for the detailed requirements for transfer agreements.)



## 202. CHRISTIAN SCIENCE SANATORIUM

A **Christian Science sanatorium** operated or listed and certified by the First Church of Christ, Scientist, Boston, Mass., may qualify as both a **hospital** and **extended care facility**. There is provision for the payment of separate benefits in each case. Inpatient care in such an institution can begin or prolong a "spell of illness" (§ 220). Payment can be made in the same spell of illness for both inpatient hospital services furnished in a hospital and those furnished by a sanatorium in its capacity as a hospital, but the total days of covered care cannot exceed the maximum of 90 days in a spell of illness (§ 110.2).

Sanatorium services are considered to be furnished by a sanatorium in its capacity as a hospital unless the individual elects to have them treated as sanatorium extended care services.

Payment for sanatorium **extended care services** may be made **for up to 30 days** in each spell of illness, instead of the 100 days applicable to extended care services generally.

Payment may not be made for posthospital extended care services furnished to an inpatient of an extended care facility which is not a Christian Science sanatorium after he has been furnished, during the same spell of illness, covered sanatorium extended care services. Similarly, payment may not be made on behalf of an individual for sanatorium extended care services furnished him after he has been furnished posthospital extended care services during the same spell of illness as an inpatient of a qualified extended care facility which is not a Christian Science sanatorium.

## 203. HOSPITAL DEFINED

A **Hospital (Other Than Tuberculosis or Psychiatric)** is an institution which:

a. is primarily engaged in providing to inpatients, by or under the supervision of physicians,

(1) diagnostic and therapeutic services for medical diagnosis, treatment, and care of injured, disabled, or sick persons, or

(2) rehabilitation services for the rehabilitation of injured, disabled, or sick persons;

b. maintains clinical records on all patients;

c. has bylaws in effect concerning its staff of physicians;

d. requires that every patient must be under the care of a physician;

e. provides 24-hour nursing service by or supervised by a registered professional nurse, and has a licensed practical nurse or registered professional nurse on duty at all times;

f. has in effect a hospital utilization review plan;

g. is licensed or is approved by the State or local licensing agency as meeting the standards established for such licensing;

h. is in substantial compliance with other health and safety requirements of the Secretary of Health, Education, and Welfare. (These additional requirements may not be higher than comparable ones prescribed for accreditation by the Joint Commission on Accreditation of Hospitals with certain exceptions specified in the law.);

i. is not primarily for the care and treatment of mental diseases or tuberculosis.

**203.1 Psychiatric and Tuberculosis Hospitals.**—A psychiatric hospital is an institution which is primarily engaged in providing by or under the supervision of a physician, psychiatric services for the diagnosis and treatment of mentally ill persons.

A tuberculosis hospital is an institution which is primarily engaged in providing by or under the supervision of a physician, medical services for the diagnosis and treatment of tuberculosis.

To qualify as a psychiatric or tuberculosis hospital the institution must be accredited by the Joint Commission on Accreditation of Hospitals, have in effect a utilization review plan, and meet additional staffing and medical record requirements.

A distinct part of a psychiatric or tuberculosis institution may qualify as a psychiatric or tuberculosis hospital independently of the institution of which it is a part, if the part meets certain specified requirements.

**203.2 Hospital for Emergency Services.**—A nonparticipating hospital within the United States may receive payment for covered emergency inpatient hospital services and outpatient hospital diagnostic services if it meets the requirements in the definition of a hospital, except for the utilization review and health and safety requirements. Coverage continues only as long as the emergency continues.

Emergency inpatient hospital services outside the United States are covered under limited conditions arising ordinarily only in border areas.

## 205. PARTICIPATING PROVIDERS OF SERVICES

Providers of services are Hospitals, Extended Care Facilities, and Home Health Agencies.

Payment may ordinarily be made only to a **participating** provider for covered services furnished by the provider or by others under arrangements with the provider. A participating provider is an institution, facility, or agency which has been approved by the



Social Security Administration as a provider of services, and has entered into an agreement with the Administration which provides that it will not charge any patient or other person for covered items and services, for which an individual is entitled to have payment made under the program; will return any money incorrectly collected; and will provide services on a non-discriminatory basis in compliance with Title VI of the Civil Rights Act of 1964.

## **206. UNDER ARRANGEMENTS**

A provider may make arrangements with others to furnish covered items or services. When such arrangements are made, receipt of payment by the provider for the services (whether it bills in its own right or on behalf of those furnishing the services) must relieve the beneficiary or any other person of further liability to pay for the services.

### **Coverage of Services Under Hospital Insurance**

## **210. REQUIREMENTS—GENERAL**

Effective January 1, 1967, posthospital extended care services furnished to inpatients of an extended care facility are covered under the hospital insurance program. Patients having hospital insurance coverage are entitled to have payment made on their behalf for the reasonable cost of covered extended care services furnished by the facility, by others under arrangements with the facility, or by a hospital with which the facility has a transfer agreement in effect.

## **211. PRIOR HOSPITALIZATION AND TRANSFER REQUIREMENTS**

In order to have payment made for posthospital extended care services, the individual must have been an inpatient of a hospital for at least 3 consecutive calendar days and have been transferred to an extended care facility within 14 days after discharge from the hospital.

**211.1 Three-Day Prior Hospitalization.**—The hospital discharge must occur after June 30, 1966, or on or after the first day of the month in which the individual attains age 65, whichever is later. In determining whether the required 3-day period of hospitalization has been met, the day of admission, **but not the day of discharge**, is counted as a hospital inpatient day.

The hospital need not be one with which the extended care facility has a transfer agreement; but must at least be one which meets all of the requirements in the definition of hospital, except the utilization review and health and safety requirements.

To be covered, the extended care services must have been necessitated by a condition which occasioned the patient's qualifying hospital stay, or by a condition which arose while in the facility for treatment of a condition for which he was previously hospitalized.

**211.2 Fourteen-Day Transfer.**—In determining the 14-day period, the day of discharge from the hospital is not counted in the 14 days. For example, a patient discharged from a hospital on August 1, and admitted to an extended care facility on August 15 was admitted within 14 days.

If the individual leaves the extended care facility and is readmitted to the same, or any other qualified extended care facility (see § 201) within 14 days, he is deemed not to have been discharged from an extended care facility for purposes of this requirement. Thus, the period of extended care services may be interrupted briefly and then resumed, if necessary, without hospitalization preceding the readmission to a qualified facility.

Hospitalization within the 14-day period after discharge from an extended care facility may also be treated as a return to an extended care facility within the 14-day period. For example, a person suffers a relapse which requires a resumption of skilled nursing care within 14 days after he is discharged from an extended care facility. Because there is no bed available in an extended care facility, he is placed in a hospital for less than 3 days and is then placed in a qualified extended care facility. Under these conditions, the person would be considered as having returned to an extended care facility within the 14-day period, even if the second admission to the extended care facility occurs more than 14 days after his first discharge from such a facility.

**211.3 Requirements Applicable to Extended Care Facility Inpatients on January 1, 1967.**—A hospital insurance beneficiary who is an inpatient of an extended care facility prior to January 1, 1967, the effective date of extended care coverage, is entitled to have payment made for extended care services beginning January 1, 1967, providing (1) he is on that date an inpatient of an institution which becomes a participating provider as of that date and (2) he was transferred to that facility within 14 days of his discharge from a hospital of which he was an inpatient for 3 consecutive calendar days, and (3) he was discharged from the hospital after June 30, 1966, or on or after the first day of the month in which he became age 65, whichever is later, and (4) he has not been out of a facility for more than a 14-day period (see § 211.2 above).

## 212. COVERED EXTENDED CARE SERVICES

Patients covered under hospital insurance are entitled to have payment made on their behalf on a reasonable cost basis for covered extended care services. If a patient receives items or services in excess of, or more expensive than those for which payment can be made, payment will be made only for the reasonable cost of the covered items or services. If the items or services were requested by the patient, the facility may charge him the difference between the amount customarily charged for the services requested and the amount customarily charged for covered services.

An **inpatient** is a person who has been admitted to an extended care facility for bed occupancy for purposes of receiving inpatient services. A person is considered an inpatient if formally admitted as an inpatient with the expectation that he will remain at least over night and occupy a bed even though it later develops that he can be discharged and does not actually use a bed over night.

**Note: Custodial care (see § 240.9) is not covered extended care service.**

The following extended care services are covered under hospital insurance:

### 212.1 Nursing Care Provided by or Under the Supervision of a Registered Professional Nurse.—

**Note: The services of a private-duty nurse or other private-duty attendant are not covered.** Private-duty nurses or private-duty attendants are registered professional nurses, licensed practical nurses, or any other trained attendant whose services are restricted to a particular patient by arrangement between the patient and the private-duty nurse or attendant.

**212.2 Bed and Board in Semiprivate Accommodations.**—Hospital insurance will pay for the reasonable cost of semiprivate accommodations (two, three, or four-bed accommodations) in connection with nursing care. When accommodations other than semiprivate are furnished, the following rules will govern.

**A. Private Rooms Medically Necessary.**—Payment may be made for the reasonable cost of a private room or other accommodations more expensive than semiprivate only when such accommodations are medically necessary. Private rooms will be considered medically necessary when the patient's condition requires him to be isolated for his own health or that of others.

The term isolation may apply when treating a number of physical and mental conditions. These include

communicable diseases which require isolation of the patient for certain periods. Privacy may also be necessary for patients whose symptoms or treatment are likely to alarm or disturb others in the same room.

**B. Private Rooms Not Medically Necessary.**—When accommodations more expensive than semiprivate are furnished the patient because, at the time of admission, less expensive accommodations are not available, the program may pay only the reasonable cost of semiprivate accommodations.

When accommodations more expensive than semiprivate are furnished the patient **at his request** in the absence of medical necessity, the facility may charge the patient no more than the difference between the customary charges for the accommodations furnished and the customary charges for semiprivate accommodations at the most prevalent rate at the time of admission. No such charge may be made to the patient unless he requested the more expensive accommodations. (See D. below for a definition of "customary charges" and "most prevalent rate.")

**C. Wards.**—When accommodations less expensive than semiprivate are furnished **at the patient's request or for a reason determined to be consistent with the purposes of the health insurance program**, payment may be made for the reasonable cost of the accommodations furnished. It is considered to be consistent with the program's purposes to furnish bed and board in less expensive accommodations where semiprivate accommodations are not available. However, the patient must be moved to semiprivate accommodations when they become available. (Payment to extended care facilities which have **only** ward accommodations will be made on the basis of the reasonable cost of the accommodations furnished.)

In some cases, a patient may be placed in accommodations less expensive than semiprivate **neither at his request nor for a reason consistent with the program's purposes**. It is not consistent with the purposes of the law to assign a patient ward accommodations on the basis of his social or economic status, his national origin, race, or religion, or his entitlement to benefits as a medicare patient, or any other discriminatory reason, when the patient has not requested such assignment. An extended care facility which repeatedly assigns patients to accommodations less expensive than semiprivate neither at the patient's request nor for reasons consistent with the purposes of the program will be subject to termination of its participation agreement.

When ward accommodations are furnished neither at the patient's request nor for a reason consistent with



the program's purpose, reimbursement will be made at a reduced rate. The payment to be made shall be the reasonable cost of semiprivate accommodations minus the difference between the institution's customary charges for semiprivate accommodations at the most prevalent rate (see D. below) at the time of the patient's admission and the charge customarily made for the accommodations furnished the patient by the institution. (For example, the reasonable cost of semiprivate accommodations is \$15 per day. The most prevalent customary charge rate for a semiprivate room was \$17 per day and \$10 per day the customary charge for ward accommodations. The extended care facility would be paid \$8 per day for the ward accommodations, i.e., \$17 minus \$10 equals \$7; \$15 minus \$7 equals \$8.) However, payment will not be made for more than the reasonable cost of ward accommodations regardless of the amount indicated by the use of this formula. The reduction in payment, when appropriate, will be made at the end-of-year settlement.

**D. Customary charges** means amounts which the extended care facility is uniformly charging patients currently for specific services and accommodations. The **most prevalent rate** for semiprivate accommodations is the rate which applies to the greatest number of semiprivate beds.

### **212.3 Physical, Occupational and Speech Therapy Furnished by the Extended Care Facility or by Others Under Arrangements Made by the Facility.—**

**A. Physical therapy** includes assistance to the physician in evaluating patients by applying diagnostic and prognostic muscle, nerve, joint, and functional ability tests, and treating patients to relieve pain, develop or restore function, and maintain maximum performance, using physical means such as exercise, massage, heat, water, light, and electricity.

A qualified physical therapist is licensed or registered by the State when licensure laws are applicable, and meets the following criteria:

1. Graduation from a physical therapy curriculum approved by the American Physical Therapy Association from 1928 to 1936, or by the Council on Medical Education and Hospitals of the American Medical Association from 1936 to 1960, or by the Council on Medical Education of the American Medical Association in collaboration with the American Physical Therapy Association since 1960; or

2. Membership in the American Physical Therapy Association or registration by the American Registry of Physical Therapists; or

3. If the physical therapist was trained outside the United States:

- a. Graduation since 1928 from a physical therapy curriculum approved in the country in which the curriculum was located, and the curriculum must have been in a country in which there is a member organization of the World Confederation for Physical Therapy; and

- b. Membership in a member organization of the World Confederation for Physical Therapy; and

- c. Completion of 1 year's experience under the supervision of an active member of the American Physical Therapy Association; and

- d. Successful completion of a qualifying examination as prescribed by the American Physical Therapy Association.

An individual who graduated from any school before its physical therapy curriculum was approved by the appropriate organization mentioned in 1. above is not a qualified physical therapist unless, of course, he is a member of the American Physical Therapy Association or is registered by the American Registry of Physical Therapists.

**B. Speech therapy** includes assistance to the physician in evaluating patients to determine the type of speech or language disorder and the appropriate corrective therapy; providing rehabilitative services for speech and language disorders.

A speech therapist is certified by the American Speech and Hearing Association, or has completed the academic requirements and is in the process of accumulating the necessary supervised work experience required for certification.

**C. Occupational therapy** includes assistance to the physician in evaluating the patient's level of function by applying diagnostic and prognostic tests; guiding the patient in his use of therapeutic creative and self-care activities for improving function.

An occupational therapist is registered by the American Occupational Therapy Association or is a graduate of a program approved by the Council on Medical Education of the American Medical Association in collaboration with the American Occupational Therapy Association and is in the process of accumulating supervised clinical experience required for registration.

An occupational therapy assistant is one who works under the supervision of a qualified occupational therapist and has successfully completed a training course approved by the American Occupational Therapy Association, and is certified by that body as a certified occupational therapy assistant.



**212.4 Medical Social Services To Meet the Patient's Medically Related Social Needs.**—Medical social services include, but are not limited to, (a) assessment of the social and emotional factors related to the patient's illness, his need for care, his response to treatment, and his adjustment to care in the facility; (b) appropriate action to obtain case work services to assist in resolving problems in these areas; (c) assessment of the patient's medical and nursing requirements, his home situation, his financial resources, and the community resources available to him in making the decision regarding his discharge; (d) arrangements for referral to the appropriate agency where a need for financial assistance is indicated.

**212.5 Drugs and Biologicals.**—Drugs and biologicals for use in the facility which are ordinarily furnished by the facility for the care and treatment of inpatients are covered.

Two basic requirements must be met in order for a drug or biological furnished by a facility to be included as a covered extended care service. The drug or biological must (1) represent a cost to the institution in rendering services to the beneficiary; and (2) the drug or biological must either be included, or approved for inclusion, in the U.S. Pharmacopoeia, the National Formulary, the U.S. Homeopathic Pharmacopoeia, or New Drugs or Accepted Dental Remedies (except for those unfavorably evaluated).

**A. Drugs Included in the Drug Compendia.**—Coverage is provided only for those drugs and biologicals included, or approved for inclusion, in the latest official editions of the compendia. The latest official editions or revisions are: (1) U.S. Pharmacopoeia, 17th Revision, official from September 1, 1965, (2) the National Formulary, 12th Edition, official from September 1, 1965, (3) U.S. Homeopathic Pharmacopoeia, 7th Revised Edition, 1964, (4) New Drugs, 1966, and (5) Accepted Dental Remedies, 1966.

The exclusion from coverage of drugs and biologicals unfavorably evaluated in New Drugs and Accepted Dental Remedies applies to those drugs and biologicals which have been unfavorably evaluated for **all** medicinal uses. If a drug or biological has been unfavorably evaluated for one or more, **but not all**, medicinal uses, the exclusion applies only where the drug has been unfavorably evaluated for the medicinal use to which it is being put.

Drugs and biologicals are considered "approved for inclusion" in a compendium if approved under the established procedure by the professional organization responsible for revision of the compendium.

**B. Drugs Not Included in the Compendia.**—

Drugs not included, or approved for inclusion, in the drug compendia are nevertheless covered if such drug (1) was furnished the patient during his prior hospitalization, (2) was approved for use in the hospital by the hospital's pharmacy and drug therapeutics (or equivalent) committee; and (3) is required for the continuing treatment of the patient in the extended care facility.

**C. Combination Drugs.**—Combination drugs are covered if the combination itself or all the therapeutic ingredients of the combination are included, or approved for inclusion, in any of the designated drug compendia. Under the limited circumstances mentioned in B. above, a combination drug approved by a hospital pharmacy and drug therapeutics committee may also be covered as an extended care service.

**D. Drugs Specially Ordered for Inpatients.**—Covered drugs and biologicals are not limited to those routinely stocked by the extended care facility. A drug or biological not stocked by the facility but which the facility obtains for the patient from an outside source, such as a pharmacy in the community, is covered, if it represents a cost to the facility; that is, the facility rather than the patient is responsible for making payment to the supplier. Whether a drug or biological is covered under such circumstances depends upon the financial arrangements with respect to the individual transaction. It is not required that the same practice be followed by the facility for all patients in obtaining drugs from an outside source. For example, the fact that public assistance payments for drugs furnished to a welfare patient are made to the pharmacy in the community, rather than the facility (which in this case does not incur a cost for the drug), does not preclude coverage of the same drugs when purchased directly by the facility for the use of other patients.

**E. Drugs for Use Outside the Facility.**—Drugs and biologicals furnished by a facility to an inpatient for use outside the facility are, in general, not covered as extended care services. However, if the drug or biological is deemed medically necessary to permit or facilitate the patient's departure from the facility, and a supply is required until he can obtain a continuing supply, the drugs or biologicals would be covered as an extended care service. Drugs and biologicals furnished to outpatients of extended care facilities are not covered.

**212.6 Supplies, Appliances, and Equipment.**—Supplies, appliances, and equipment furnished for use in the facility, which are ordinarily furnished by the facility for the care and treatment of inpatients are covered extended care services. However, under cer-

tain circumstances, supplies, appliances, and equipment used during the beneficiary's stay are covered even though they leave the facility with the patient when he is discharged. These are circumstances in which it would be unreasonable or impossible from a medical standpoint to limit the patient's use of the item to the periods during which the individual is an inpatient. An example of items covered under this rule is a brace temporarily attached to the patient's body while he is receiving treatment as an inpatient and which is also necessary to permit or facilitate the patient's release from the facility.

Supplies, appliances, and equipment furnished to a patient for use **only** outside the facility would not, in general, be covered as extended care services. However, a temporary or disposable item provided to a patient which is medically necessary to permit or facilitate his departure from the facility and is required until such time as he can obtain a continuing supply would be covered as an extended care service.

**212.7 Medical Services of an Intern or Resident-in-Training.**—The medical services of an intern or resident-in-training under an approved teaching program of a hospital with which the facility has in effect the required transfer agreement are covered under hospital insurance.

An "approved teaching program" means a program approved by the Council on Medical Education of the American Medical Association or, in the case of an osteopathic hospital, approved by the Committee on Hospitals of the Bureau of Professional Education of the American Osteopathic Association. In the case of services of an intern or resident-in-training in the field of dentistry in a hospital or osteopathic hospital, the teaching program must have the approval of the Council on Dental Education of the American Dental Association.

The medical and surgical services furnished to the facility's patients by interns and residents-in-training of a hospital with which the facility has a transfer agreement are covered under medical insurance if the services are not covered under hospital insurance.

The services performed by interns and residents—including a physician acting in the capacity of an intern or resident—are reimbursable to the facility on a reasonable cost basis even though the intern or resident is a licensed physician. These services are not reimbursable on a reasonable charge basis as physicians' services.

**212.8 Other Diagnostic or Therapeutic Services Provided by a Hospital.**—Extended care services also include other diagnostic or therapeutic serv-

ices provided by a hospital with which the facility has a transfer agreement.

**212.9 Other Services.**—Other services which are necessary to the health of the patients are covered if the services are the type generally provided by extended care facilities. For example, the use of an operating room would not be covered since operating rooms are not generally maintained as part of such facilities. Items or services that would not be included as inpatient hospital services if furnished to an inpatient of a hospital are also excluded from extended care coverage. See § 110.2 for summary of inpatient hospital services.

## Services Covered Under Medical Insurance

### 213. AMBULANCE SERVICE

An ambulance is a specially designed or equipped automobile or other vehicle (in some areas of the United States this might be a boat or plane) for transporting the sick or injured. It must have customary patient care equipment such as a stretcher, clean linens, first aid supplies, oxygen equipment, and it must also have such other safety and lifesaving equipment as is required by State or local authorities. Personnel whose duties involve the care or handling of the patient while providing ambulance service must have adequate training in the application of first aid, i.e., training which is at least equivalent to the training provided by the standard and advanced Red Cross first aid courses. The driver would not have to meet the first aid training requirement if there is at least one other person assigned to the ambulance who has had the required training. Training "equivalent" to the standard and advanced Red Cross first aid training courses includes ambulance service training and experience acquired in military service, successful completion by the individual of a comparable first aid course furnished by or under the sponsorship of State or local authorities, an educational institution, a fire department, a hospital, a professional organization, or other such qualified organization. On-the-job training involving the administration of first aid under the supervision of or in conjunction with trained first aid personnel for a period of time sufficient to assure the trainee's proficiency in handling the wide range of patient care services that may have to be performed by a qualified attendant can also be considered as "equivalent training."

**A. For coverage of ambulance services** each of the following three conditions must be met:

1. The vehicle utilized to provide the ambulance service and the ambulance personnel whose duties in-



volve care of the individual to be transported by the ambulance meet the requirements specified above;

2. Ambulance service is covered only where the use of any other method of transportation is medically contraindicated by the patient's conditions. (In any case in which some means of transportation other than an ambulance could be utilized without endangering the individual's health, whether or not such other transportation is actually available, no payment may be made for ambulance service.)

3. The patient must have been transported to the nearest hospital with appropriate facilities or to one in the same locality, and under similar restrictions, from one hospital to another, or to an extended care facility. The patient may, likewise, be transported from one of these institutions to his home (or place of residence) if such home is within the locality of the institution.

The requirement that a patient be transported to the **nearest hospital with appropriate facilities** or to one in the **same locality** as that hospital (and under similar restrictions from one hospital to another, to the patient's home, or to an extended care facility) is intended to provide coverage of essential ambulance service, without imposing an arbitrary "mileage" limitation. It is not contemplated, however, that payment would be made for ambulance services that involve transporting the patient beyond the locality even if the patient is transported to a participating hospital or extended care facility. The term **locality**, with respect to ambulance service, means the service area in the geographic territory surrounding the institution from which individuals normally come or are expected to come for medical services.

The term **appropriate facilities** means that the institution has available the services, supplies, and staff necessary to provide the medical care called for by the patient's injury or illness. The fact that a more distant institution is better equipped, either qualitatively or quantitatively, to care for the patient does not warrant a finding that a closer institution does not have "appropriate facilities." However, a patient need not necessarily be taken to the nearest hospital or facility with appropriate facilities; he can be taken to another hospital or facility in the same locality.

**B. If an ambulance is operated by an extended care facility**, reimbursement for this service is made under the supplementary medical insurance program on a reasonable cost basis. The cost of oxygen administered in connection with ambulance service is also covered. See § 252.1 for required physician certi-

cation for coverage of extended care facility furnished ambulance service.

## Facility-Based Physicians

### 215. FACILITY-BASED PHYSICIANS' SERVICES

The medical insurance program covers the reasonable charges for physicians' services rendered to individual beneficiaries. The charges of facility-based physicians (e.g., those on salary) for services directed to the medical care of the individual patient must be specially billed either by the physician or by the facility on his behalf. However billed, reimbursement is made for medical services to individual patients on a reasonable charge basis by the supplementary medical insurance (Part B) intermediary. (See § 404 for billing by the facility for these services.)

Facility-based physicians often perform services other than those clearly directed to the medical care of individual patients. These may involve teaching and administrative services, and other services that benefit the facility's patients as a group. Such physician services, not directly related to an individual patient, if compensated, must be considered in computing reimbursable facility costs and, as such, will be reflected in amounts payable to the facility under Part A for services rendered program beneficiaries.

Detailed information on reasonable cost and charge computation is contained in "Principles of Reimbursement for Provider Costs and for Services by Hospital-Based Physicians." These principles establish the criteria for distinguishing between the services of facility-based physicians which are reimbursable as provider services and those services reimbursable as physicians' services to patients. The principles also establish a basis for determining the reasonable charges for physicians' services to patients where, under the existing arrangement between the facility and the physician, billings to patients have not separately identified charges for physicians' services to patients. Where charges for physicians' services to patients have been identified separately, the customary charges for physicians' services have been established and afford a basis for determining the reasonable charges for such services. Finally, the principles establish a basis for ascertaining the customary charges for a physician's services to patients where, under a previous arrangement between the facility and the physician, charges to patients were not separately identified, but this arrangement is modified and the facility and the physician agree to bill patients separately for their respective services.



The extended care facility's Part A intermediary will obtain from the facility information it and the Part B carrier need to make payment determinations where the services of facility-based physicians are involved. The Part A intermediary has the responsibility for reviewing and approving the reasonableness of the agreement between facility and physician on the allocation of physician compensation (received from or through the facility) between (1) the portion attributable to provider services, i.e., services to the institution and (2) the portion attributable to physician services, i.e., identifiable services rendered by the physician to individual patients. If the facility and physician fail to agree or if their agreement appears unreasonable, the Part A intermediary and the Part B carrier will jointly assist in resolving the issue. The Part B carrier is responsible for review and approval, in accordance with the applicable principles, of the basis for Part B charges for services of facility-based physicians, i.e., the schedule of such charges if the item-by-item method of determination is used, or the uniform percentage if the optional method of determination is used.

### **Duration of Covered Extended Care Services**

#### **220. SPELL OF ILLNESS DEFINED**

A spell of illness is a period of consecutive days that **begins** with the first day (not included in a previous spell of illness) on which a patient is furnished inpatient hospital or extended care services by a qualified provider in a month for which the patient is entitled to hospital insurance benefits. A qualified hospital (including a psychiatric or tuberculosis hospital) or extended care facility is one that has been certified as meeting all the requirements of the definition of such an institution. A hospital which meets the requirements in § 203.2 is a qualified hospital for purposes of beginning a spell of illness when it furnishes the patient covered inpatient emergency services.

**Generally, the spell of illness begins when covered inpatient services are initially furnished to an entitled individual.**

However, admission to a qualified extended care facility will begin a spell of illness even though payment for the services cannot be made because the prior hospitalization or transfer requirement has not been met. (See § 211.)

The spell of illness *ends* with the close of a period of 60 consecutive days during which the patient was neither an inpatient of a hospital nor an inpatient of an extended care facility. To determine the 60 consecutive day period, begin counting with the day **following**

the day on which the individual was discharged. **It is important to note that for purposes of continuing a spell of illness the hospital or extended care facility in which the stay occurs need not meet all of the requirements that are necessary for starting a spell of illness.**

Inpatient services will prolong the beneficiary's spell of illness if the hospital meets the initial requirement of the definitions in §§ 203 and 203.1. That is, it is primarily engaged in providing, by or under the supervision of physician(s), to inpatients (1) diagnostic and therapeutic services for medical diagnosis, treatment, and care of injured, disabled, or sick persons, or rehabilitation services for injured, disabled, or sick persons; or (2) psychiatric services for the diagnosis and treatment of mentally ill persons; or (3) medical services for the diagnosis and treatment of tuberculosis.

Similarly, inpatient services in an **extended care facility** will prolong a beneficiary's spell of illness if the facility (including one primarily for the care and treatment of mental diseases or tuberculosis) meets at least requirement 201.a of the definition. That is, it is primarily engaged in providing to inpatients skilled nursing care and related services for patients who require medical or nursing care, or rehabilitation services for injured, disabled, or sick persons.

An individual may be discharged from and readmitted to a hospital or extended care facility several times during a spell of illness and still be in the same spell if 60 days have not elapsed between discharge and readmission. Inpatient stays during the same spell of illness need not be for the same or related physical or mental conditions. (For necessary relationship of extended care facility patient's condition to prior hospitalization, see § 211.)

As long as a person continues to be entitled to hospital insurance, there is no limit to the number of spells of illness he may have.

**Example 1:** X was born August 9, 1902. On July 28, 1967, X entered a participating general hospital. After he had been in the hospital for 2 weeks X was discharged on August 11, 1967. On his doctor's orders X entered a participating extended care facility on August 15, 1967, and remained there until his discharge on October 27, 1967. He had no further inpatient stays in 1967. X's spell of illness began on August 1, 1967, the first day of the month he attained age 65 and was entitled to hospital insurance. The spell of illness ended December 26, 1967, 60 days after his last discharge.

**Example 2:** Y, over age 65, entered a participating general hospital on July 28, 1968, for treatment

of a heart condition. He was discharged on August 11, 1968. On August 20, 1968, Y entered a *nonparticipating nursing home*, which provided primarily skilled nursing care and related services. Y remained in this facility until his discharge on October 27, 1968. On December 25, 1968, Y was again admitted to a participating hospital because of injuries suffered in an accident. He was discharged on January 13, 1969, and had no further inpatient stays in 1969. Y's spell of illness began on July 28, 1968: His stay in the nursing home began less than 60 days after his hospital discharge and the spell was continued even though the stay was not covered. The subsequent hospital stay began less than 60 days after the nursing home discharge and continued the spell of illness, although the condition treated was unrelated to his prior stays. The spell ended on March 14, 1969.

**Example 3:** Z, over age 65 and entitled to hospital insurance benefits, was admitted to General Hospital on August 1, 1966, and discharged on August 10, 1966, having received nonemergency hospital services. General Hospital met all the requirements in the definition of a hospital except those concerning utilization review and health and safety. While General Hospital met the minimum requirements for a prior-stay hospital, Z's *spell of illness did not begin* with his admission to this hospital because (1) the hospital did not meet all of the requirements in the definition of a hospital; and (2) although the hospital satisfied the requirements for coverage of emergency services, Z did not receive emergency inpatient care. Z was admitted to Haven Convalescent Home on August 20, 1966, and remained an inpatient of the home until his discharge on March 1, 1967. He had no further inpatient stays in 1967. Haven Convalescent Home became a participating extended care facility on January 1, 1967. Z's spell of illness began January 1, 1967, the day Haven Convalescent Home was determined to be a qualified extended care facility and the services Z received on that date were covered extended care services. Z's spell of illness *ended* April 30, 1967, 60 days after his discharge from the convalescent home.

## 222. EXTENDED CARE BENEFIT DAYS

A patient having hospital insurance coverage is entitled to have payment made on his behalf for up to 100 days of covered inpatient extended care services in each spell of illness. (For coinsurance provision, see § 226.)

The number of days of care charged to a beneficiary for extended care services will always be in units of

full days. A day begins at midnight and ends 24 hours later. Facilities may use a different definition of day for statistical or other purposes, but in reporting days of care used by beneficiaries, the midnight-to-midnight method is to be used. With the exception of the day of discharge, a day on any part of which an individual is an inpatient is counted as an inpatient day. In counting inpatient days for reimbursement purposes and in determining the total number of days of inpatient care utilized by the beneficiary, the day of admission is counted, but the day of discharge is not counted. This recognizes that the day of admission and the day of discharge are partial days. If admission and discharge occur on the same day, the day is considered a day of admission and counts as 1 inpatient day.

## 224. SERVICES COUNTING TOWARD MAXIMUMS

Extended care services count toward the maximum number of benefit days payable per spell of illness only if:

- (1) Payment for the services is made, or
- (2) Payment for the services would be made if a request for payment were properly filed and if the physician certified that the services were medically necessary. Where payment cannot be made because of the extended care coinsurance requirement, the day(s) used in satisfying this requirement nevertheless count toward the beneficiary's maximum days of extended care.

## 226. COINSURANCE—EXTENDED CARE SERVICES

The beneficiary is responsible for a coinsurance amount, initially \$5, (one-eighth of the inpatient hospital deductible) for each day after the 20th and through the 100th day of extended care services furnished during a spell of illness.

## General Exclusions From Coverage

### 240. GENERAL EXCLUSIONS

No payment can be made under **either** the hospital insurance or supplementary medical insurance programs for the following items and services:

**240.1 Items and services which are not reasonable and necessary** for the diagnosis or treatment of illness or injury or to improve the functioning of a malformed body member are not covered. Potential personal comfort items and services such as massages and heat lamp treatments are not covered unless they



contribute meaningfully to the treatment of an illness or injury, or the functioning of a malformed body member.

**240.2 Items and Services for Which There is No Legal Obligation to Pay.**—Free services are excluded from coverage, e.g., free chest x-rays provided by health organizations.

This exclusion does not apply if the patient has a legal obligation to pay, or some other person or organization has a legal obligation to pay for or provide the items or services. Thus, benefits for covered items and services would be paid by the program even though the same services were covered by a prepayment plan or health insurance policy. Such a plan may pay money toward the cost of services or it may maintain its own facilities and professional supporting staff.

In applying this exclusion the determining factor is that there is no legal obligation to pay for the items or services, and not merely the fact that the patient is not charged because of other considerations. This exclusion, therefore, does not prohibit program payment for services rendered to:

A. **Members of religious orders** who are not charged because of a vow of poverty;

B. **Indigents** who because of their inability to pay are not charged by an institution which customarily charges for such services;

C. **The patient whose need for services resulted from the act or negligence of another** who is or may be legally liable for the patient's medical expenses. The existence of a third person's liability does not affect the patient's obligation to pay for the services he receives;

D. **Certain residents of homes for the aged.**—Coverage of health services furnished to a resident of a home for the aged depends on the agreement under which the services are provided.

1. The typical relationship between the **proprietary or profit-making home** and the residents is contractual. The home agrees to furnish or pay for certain services, including specified health services, in return for specified payments by the resident. Payment can be made under the health insurance program for the specified health services received by the resident of such a home since the home has a legal obligation to pay for or provide the services. Of course, payment may also be made for covered services not included in the resident's contract with the home, which he himself has a legal obligation to pay.

2. **Nonprofit homes** are generally operated by religious or fraternal organizations. The resident is ordinarily required to contribute to the cost of his maintenance

and health care to the extent that he is able. For example, the resident is usually required to assign to the home assets or income at the time of admission. Where this is the case, payment can be made under the program for covered services furnished the resident whether or not his circumstances permitted him to pay anything for his care.

However, where all services are furnished by the home on a purely charitable basis (i.e., no payment is accepted from residents regardless of their ability to pay), payment could not be made under the health insurance program for items and services furnished by the home. In this situation, however, payment could be made for services furnished by a source independent of the home if that source customarily charges for such services. Thus, payment could be made for services furnished by a hospital or extended care facility to which a resident of the home is sent, or for home health services furnished by an agency, or for the services of a physician who is not an employee of the home.

3. **Certain union homes** accept no payment from residents regardless of their ability to pay. Payment may, nevertheless, be made for services provided by such homes where admission to the home and access to the services is a matter of right for union members who meet the necessary qualifications.

4. **Homes for Members of Religious Orders.**—Many religious orders maintain homes similar to retirement homes to care for members who become ill or infirm. Since members of the order are under a vow of poverty, there is no charge made by the home for this care. The order is considered to have an obligation to care for its members who have rendered lifelong services. Payment may be made for services furnished in these homes, whether they are furnished by the home itself or by independent sources that customarily charge for their services.

**240.3 Items and services which are paid for by a governmental entity** other than under a title of the Social Security Act, such as a medical assistance program, or under a health benefits or insurance plan for employees of the governmental entity are not covered. The Secretary of Health, Education, and Welfare may specify other exceptions to this exclusion. The Secretary has approved payment for covered items and services even though provided free, if

A. furnished by participating State or local government-operated hospitals, including psychiatric and tuberculosis hospitals which serve the general community but not including hospitals which serve a special category of the population, e.g., prison hospitals, or



B. paid for by a State or local governmental entity and furnished an individual as a means to control infectious diseases or to provide for the medically indigent. These services need not be furnished in a hospital. Payment may be made for items and services furnished by a government-operated home for the indigent aged whether supplied directly by the home or purchased by it from independent physicians and hospitals. Payment may also be made for services furnished by a participating State-operated Veterans' Home and Hospital, provided the patient would, in the absence of program coverage, have been charged for the items and services, or he was admitted to the facility without charge as an indigent.

**240.4 Items and services which are not provided within the United States** are not covered (except for emergency inpatient hospital services furnished outside the United States under the conditions described in § 203.2 and payment on behalf of railroad beneficiaries for covered hospital insurance services furnished in Canadian hospitals). The United States includes the 50 States, the District of Columbia, the Commonwealth of Puerto Rico, the Virgin Islands, Guam, and American Samoa.

**240.5 Items and services which are required as a result of war, or of an act of war, occurring after the effective date of the patient's current coverage** are not covered.

**240.6 Personal Comfort Items.**—Items which do not contribute meaningfully to the treatment of an illness or injury or the functioning of a malformed body member are not covered.

**240.7 Routine physical checkups; eyeglasses and eye examinations for the purpose of prescribing, fitting, or changing eyeglasses; hearing aids and examinations for hearing aids; and immunizations** are not covered. Routine physical checkups include (a) examinations performed without relationship to treatment or diagnosis of a specific illness, symptom, complaint, or injury, and (b) examinations required by third parties such as insurance companies, business establishments, or Government agencies.

The exclusions apply to eyeglasses or contact lenses, and eye examinations for the purpose of prescribing, fitting, or changing eyeglasses or contact lenses for refractive errors. The exclusions do not apply to services performed in conjunction with an eye disease such as glaucoma or cataracts, or to postsurgical prosthetic lenses which are customarily used during convalescence from eye surgery in which the lens of the eye was removed, or to the permanent prosthetic lenses required

by an individual lacking the organic lens of the eye, whether by surgical removal or congenital absence. Such prosthetic lens is a replacement for an internal body organ—the lens of the eye.

Vaccinations or inoculations are excluded as “immunizations” unless they are directly related to the treatment of an injury or direct exposure such as anti-rabies treatment, tetanus antitoxin or booster vaccine, botulin antitoxin, antivenin sera, or immune globulin.

**240.8 Orthopedic Shoes or Other Supportive Devices for the Feet.**—The exclusion of orthopedic shoes does not apply to such a shoe if it is an integral part of a leg brace.

**240.9 Custodial Care.**—The custodial care exclusion precludes payment for that type of care, wherever furnished, which is designed essentially to assist the individual in meeting his activities of daily living—i.e., services which constitute personal care such as help in walking and getting in or out of bed, assistance in bathing, dressing, feeding, and using the toilet, preparation of special diets, and supervision over medication which can usually be self-administered—and which does not entail or require the continuing attention of trained medical or paramedical personnel.

**240.10 Cosmetic Surgery or Expenses Incurred in Connection with such Surgery.**—Cosmetic surgery includes any surgical procedure directed at improving appearance, except when required for the prompt (as soon as medically feasible) repair of accidental injury or for the improvement of the functioning of a malformed body member. For example, this exclusion does not apply to surgery in connection with treatment of severe burns or repair of the face following a serious automobile accident or surgery for therapeutic purposes, which coincidentally also serves some cosmetic purpose.

**240.11 Charges Imposed by Immediate Relatives of the Patient or Members of His Household** are not covered.—**Immediate relative** as used in this exclusion means spouse, father, mother, son, daughter, brother, or sister—by blood, marriage or adoption. **Members of the patient's household** means those persons sharing a common abode with the patient as part of a single family unit, including those related by blood or marriage as well as domestic employees and others who live together as part of a single family unit. A mere roomer or boarder is not included.

Where a business enterprise imposes the charge, and there is a question whether this exclusion applies, a determination must be made as to whether the firm in fact represents an individual within these relationships. If

an individual proprietorship is involved, the proprietor will be considered the individual imposing the charge. A corporation is a separate legal entity which cannot be a member of a household or an immediate relative. Charges imposed by a partnership do not fall within the exclusion unless all of the partners are within the designated relationships to the patient.

**240.12 Items and services in connection with the care, treatment, filling, removal, or replacement of teeth,** or structures directly supporting the teeth are not covered. Payment may be made, however, for (a) surgery related to the jaw or any structure contiguous to the jaw, or (b) the reduction of any fracture of the jaw or any facial bone, including dental splints or other appliances used for this purpose.

**240.13 Items and services** to the extent that payment has been made, or can reasonably be expected to be made **under a workmen's compensation law** or plan of the United States or a State may not be paid for by the program. Payments for items and services under the health insurance program are subject to repayment to the appropriate trust fund if notice or information is received that payment has been made for the items and services under a workmen's compensation plan. (See §§ 258ff.)

**240.14 Items or services which the provider is obligated** by a law of or because of a contract with the Federal Government **to render at public expense** are not covered.

**240.15 Items and services are not covered when furnished by a Federal provider** of services or other Federal agency except (a) for emergency inpatient hospital services and emergency outpatient hospital diagnostic services furnished by a Federal hospital meeting the requirements of § 203.2 or (b) when the Federal provider of services has been determined by the Secretary of Health, Education, and Welfare to be providing services to the public generally as a community institution or agency.

## Requirements for Payment

### 250. REQUEST FOR PAYMENT

Before payment can be made for extended care services or physicians' services billed through an extended care facility, a written request for payment signed by the patient or by another person qualified to do so on his behalf must be filed. The signature of the patient or other qualified person may be obtained on the respective billing forms, or, under specified conditions, the facility may obtain a single signature on its records.

**250.1 Billing Forms as Request for Payment.**—Each of the billing forms (Extended Care Admission and Billing, Form SSA-1478 and Provider Billing for Patient Services by Physicians, Form SSA-1554) contains a patient signature line incorporating the patient's request for payment of benefits, authorization to release information and assignment of benefits. When the billing form is used as the request for payment, the billing form must be signed. The request for payment will then be forwarded to the intermediary or to the Social Security Administration where the extended care facility deals directly with the Government, when the facility submits its bill.

A. The billing form as request for payment will be filed in connection **with each extended care facility admission**, even though multiple admissions may occur during the same spell of illness. Only one request for payment has to be filed, however, in connection with each inpatient admission, even though an extended stay occasions multiple billings.

B. Where the billing form is used as the request for payment for **physicians' services billed through the facility**, the signature of the patient is required with each billing by the facility.

**250.2 Request for Payment on Facility Record.**—In lieu of separate signatures on the billing forms, the facility may arrange with its hospital insurance intermediary to have the patient's signature on its admission records serve as the request for payment.

The pertinent language on the billing forms must be incorporated, by printing or stamp, either in the facility's own admission forms, or on a separate form attached to or associated with the facility's admission form. Where this procedure is adopted, "Patient's request for payment on file" should be stamped on the patient's signature line of the original of each billing form to indicate that the patient's statement is on file. When the facility has arranged with its hospital insurance intermediary to put this procedure into effect, the intermediary will make payment to the facility without the patient's signature on the billing form. The Part A intermediary will verify through its regular audit activities that the signatures are being obtained as specified. The medical insurance carrier will rely on the Part A intermediary's administration of this procedure and will make payment to a facility without the patient's signature on the form SSA-1554.

The following format is suggested for the statement on the facility's record:



### **"Statement to Permit Payment of Hospital and Medical Insurance Benefits to Extended Care Facilities"**

I certify that the information given by me in applying for payment under title XVIII of the Social Security Act is correct. I authorize release of any information needed to act on this request. I request that payment of authorized benefits be made in my behalf.

I assign payment for the unpaid charges of the physician(s) for whom the facility is authorized to bill in connection with its services. I understand I am responsible for any health insurance deductibles and 20 percent of the remaining reasonable charges."

Where the facility does not bill on behalf of its facility-based physicians, the assignment part of the above statement should be omitted. Where a patient does not want to assign the benefits for services of a facility-based physician, the assignment language should be lined out in that particular case.

A. **For extended care billing**, the patient's signature will cover only that particular stay regardless of its duration. When the patient is admitted for a new stay, another request for benefits is required.

B. **When facility-based physician services are billed** under this procedure, the patient's signature on the facility record will be effective for the duration of the particular facility stay. Thus, the patient's signature will cover all form SSA-1554's filed in connection with a single stay.

### **251. EXECUTION OF THE REQUEST FOR PAYMENT**

If at all practicable, the patient should sign the request whether on the billing form or on the facility's record at the time of admission. (See Admission Procedures, §§ 300ff.)

In certain circumstances, it would be impracticable for an individual to sign the request for payment himself because when he is admitted to the facility, he is unconscious, incompetent, in great pain, or otherwise in such a condition that he should not be asked to transact any business. In this situation, his representative payee (i.e., a person designated by the Social Security Administration to receive monthly benefits on the patient's behalf), a relative, legal guardian, or a representative of an institution (other than the facility) usually responsible for his care, or a representative of a governmental entity providing welfare assistance should, if present at time of admission, be asked and permitted to sign on his behalf.

When no request for payment is obtained at the time

of admission, the facility should attempt to obtain such a request later from the patient or other person described above. If the request cannot be so obtained by the time the facility would ordinarily submit its bill to the intermediary, an authorized official of the facility may sign the request.

When someone other than the patient signs the request for payment, the signer will submit a brief statement explaining his relationship to the patient and the circumstances which made it impracticable for the patient to sign. The facility will forward this statement with its billing, or retain it in its files if the signature is obtained on the facility's own record. The intermediary will generally accept such a statement as representing the true facts of the case in the absence of evidence to the contrary.

The extended care facility should not routinely sign the request on behalf of any patient. If experience reveals an unusual frequency of such facility-signed requests from a particular facility, the matter will be subject to review by the intermediary.

If a fully competent and capable patient **refuses** to sign the request for payment necessary for the facility to obtain reimbursement for the services it furnished, the facility may charge the patient or other person for the covered services.

### **252. CERTIFICATION AND RECERTIFICATION BY PHYSICIANS**

Payment for covered posthospital extended care services may be made only if a physician makes the required certification and, where services are furnished over a period of time, the required recertification regarding the services furnished.

**252.1 Certification.**—The certification must clearly indicate that posthospital extended care services were required to be given on an inpatient basis because of the individual's need for skilled nursing care on a continuing basis for any of the conditions for which he was receiving inpatient hospital services (or services which would constitute inpatient hospital services if the institution met the conditions of participation for hospitals except those relating to utilization review and health and safety requirements) prior to transfer to the extended care facility.

The certification must be signed by the admitting physician or by a physician on the staff of the extended care facility or the attending physician in case of an emergency, who has knowledge of the case. Certifica-



tions must be obtained at the time of admission, or as soon thereafter as is reasonable and practicable. However, the method by which certifications are obtained, and the format of the certification statement, is up to the individual extended care facility. The routine admission procedure followed by a physician would not be sufficient certification of the necessity for posthospital extended care services for purposes of the program.

If **ambulance service** is furnished by an extended care facility, an additional certification is required. It may be furnished by any physician who has sufficient knowledge of the patient's case including the physician who requested the ambulance or the physician who examines the patient upon his arrival at the facility. The physician must certify that the ambulance service was medically required.

**There is no requirement that certifications be entered on any specific form or handled in any specific way, so long as the approach adopted by the facility is such as to permit the intermediary to determine that the certification requirement is in fact met. The certification can, therefore, be entered or preprinted on a form the physician already has to sign, or a separate certification form can be used.**

**252.2 Recertifications.**—The recertification statement must meet the following standards as to its contents: it must contain an adequate written record of the reasons for continued inpatient services, the estimated period of time the patient will need to remain in the facility, and plans for home care. The extended care facility may, at its option, provide a special form for this purpose. The recertification statement made by the physician has to meet the content standards, unless, for example, all of the required information is in fact included in progress notes, in which case the physician's statement could indicate that the individual's medical record contains the required information and that continued posthospital extended care services are medically necessary. A statement reciting only that continued extended care services are medically necessary is not, in and of itself, sufficient.

If the circumstances require it, the first recertification and any subsequent recertifications must state that the continued need for extended care services is for a condition requiring such services which arose after the transfer from the hospital and while the patient was still in the facility for treatment of the condition(s) for which he had received inpatient hospital services.

The recertification must be signed by the attending physician, or by a physician on the staff of the extended

care facility or the physician who is available in case of an emergency who has knowledge of the case. The form of the written record and the manner of obtaining timely recertification is up to the individual facility.

**252.3 Timing of Recertifications.**—The first recertification must be made no later than as of the 14th day of inpatient extended care services. An extended care facility can, at its option, provide for the first recertification to be made earlier, or it can vary the timing of the first recertification within the 14-day period by diagnostic or clinical categories. Subsequent recertifications must be made at intervals not exceeding 30 days. Such recertifications may be made at shorter intervals as established by the utilization review committee and the extended care facility. Utilization review of a long-stay case would not serve as an alternative to subsequent recertifications. It is expected that utilization review committees serving extended care facilities will frequently not be a part of, or as closely associated with, the provider of services as will usually be the case with utilization review committees of hospitals. Thus, the purpose of the recertification requirement will best be served by requiring a physician who is associated with the case to be responsible for subsequent recertifications.

**252.4 Delayed Certifications and Recertifications.**—Extended care facilities are expected to obtain timely certification and recertification statements. However, delayed certifications and recertifications can be honored.

In addition to complying with the content requirement otherwise applicable, delayed certifications and recertifications must include an explanation for the delay and such medical or other evidence which the extended care facility considers relevant for purposes of explaining the delay. The format of delayed certification and recertification statements, and the method by which they are obtained, are up to the individual facility. A delayed certification and recertification can appear in one statement; separate signed statements for each certification and recertification are not required as they would be if timely certification and recertification had been made.

**252.5 Disposition of Certification and Recertification Statements.**—Extended care facilities do not have to transmit certification and recertification statements to the intermediary or the Administration; instead, the facility must itself certify, on the admission and billing form, that the required physician certification and recertification statements have been obtained and are on file.

Extended care facilities are required to commit to writing and keep on file the procedure they adopt with respect to the timing of recertifications—that is, the intervals at which recertifications are required. Failure to obtain the required certification and recertification statements in an individual case will result in the facility not being eligible to receive payment in that case.

**252.6 Certification and Recertification Requirement Where Individual Admitted to Facility Before January 1, 1967.**—In the case of individuals who become inpatients of an extended care facility prior to January 1, 1967, (when extended care benefits first become payable), the physician certification will not be required. Instead, recertifications must be provided as of the time they would be required if the patient had been admitted to the extended care facility on January 1, 1967. In these cases, the initial recertification must state that posthospital extended care services were required on an inpatient basis either because of a condition for which the individual was receiving inpatient hospital services prior to transfer to the extended care facility, or for a condition which arose after the transfer to such facility and while he was still in the facility for treatment of the condition or conditions for which he received inpatient hospital services.

## **Special Provisions Related to Payment**

### **255. REFUNDS**

In its agreement for participation the extended care facility has agreed not to charge for items or services for which an individual is entitled to have payment made on his behalf, and to make adequate provision for return (or other disposition) of any money incorrectly collected from an individual or any other person on his behalf (e.g., other insurance carriers or welfare).

**A. Money incorrectly collected** means amounts in excess of a deductible or coinsurance, if applicable, paid to a facility by an individual (or other person on his behalf) as payment for covered items and services for which the individual is entitled to have payment made under the health insurance program.

**B.** The cause of an incorrect collection may be a simple error on the part of a facility in billing a beneficiary for a covered item or service. An incorrect collection may also arise in a retroactive entitlement case, or workmen's compensation case, in which the beneficiary has paid for covered services to which he later becomes entitled under health insurance.

Where the intermediary knows that a facility has

overcollected the deductible and coinsurance amounts for Part B services, it will make direct refund to the beneficiary. (See § 402, Item 19.)

**255.1 Return or Other Disposition of Money Incorrectly Collected.**—A facility in possession of an incorrect collection is required to refund or set aside the money. An equivalent amount may be withheld from payments otherwise due the facility until the facility refunds or sets aside the money incorrectly collected.

**A. Making Refund.**—Refund is to be made to the beneficiary, or other person entitled to the refund. If the proper person cannot be located after reasonable effort by the facility (including an attempt at contact by mail at the last known address), the facility should request the intermediary to have the Administration's records examined in an effort to learn the individual's address. If the individual to whom the refund is to be made still cannot be located, the facility is to make disposition of the money in accordance with the law which would be applied by the courts of the State in which the facility is located.

**B. Money Set Aside.**—Where the beneficiary's whereabouts are unknown or where there is a delay in the appointment of a legal representative to dispose of the estate of a deceased individual, as well as in other cases in which it appears that refund will be delayed indefinitely, the facility will so notify the intermediary and will then set the funds aside in a separate account, identified by the name of the individual to whom the payment is due. These amounts will be carried on the facility's records in this manner until final disposition is made in accordance with the applicable State law.

**C. Appropriate Time Limits Within Which Facility's Action Must Be Taken.**—The incorrect collection should be refunded as promptly as possible. If refund cannot be made within 60 days after the date of the notice to the facility that an incorrect collection was made, the funds must be set aside as described in B. above.

### **258. WORKMEN'S COMPENSATION**

Payment under the Health Insurance for the Aged Act is excluded for any items and services to the extent that payment has been made or can reasonably be expected to be made under a workmen's compensation law or plan of the United States or a State. This exclusion is applicable to the workmen's compensation plans of the 50 States, the District of Columbia, and Puerto Rico, as well as the systems provided under the Federal Employees Compensation Act and the Longshoremen's and Harbor Workers' Compensation Act.

Health insurance payment for items or services is



conditioned on reimbursement to the trust fund when notice or other information is received that payment for an item or service has been made under workmen's compensation.

The individual is responsible for taking whatever action is necessary to obtain payment under workmen's compensation where such payment can reasonably be expected. His failure to take proper and timely action will preclude payment under the health insurance program to the extent that payments **could** have been made under workmen's compensation.

**258.1 Effect of Workmen's Compensation Payments on Eligibility and Spell of Illness.**—An individual's spell of illness will begin with the first day he receives inpatient services from a qualified hospital or extended care facility even though workmen's compensation coverage, rather than the health insurance program, pays, or may reasonably be expected to pay, for those services, if he is entitled to hospital insurance benefits in that month. However, where workmen's compensation pays the full cost of extended care services, extended care service days will not be charged against the patient's 100 days of extended care services in a spell of illness until the first day for which payment may be made under the hospital insurance program. Charging of days will not begin until workmen's compensation coverage expires, since payment can then be made under hospital insurance if the stay continues or there is a subsequent stay not covered by workmen's compensation.

**258.2 General Procedures in Workmen's Compensation Cases.**—When the facility is told that the patient's illness or injury is employment-related, this will be indicated on the billing form, and the employer's name and address given.

If the patient has already received a workmen's compensation payment for the current illness or injury (e.g., he was a patient in the facility before the current admission) the facility should furnish the intermediary any information available with the admission notice, since it is possible that a subsequent facility stay for the same condition may also be compensable under workmen's compensation. If there is a possibility of workmen's compensation coverage, the facility should file a claim with the workmen's compensation carrier.

Even though workmen's compensation payment has been or probably will be made, the facility should submit a bill for covered health insurance services to the intermediary or to the Social Security Administration if the facility deals directly with the Government.

**A. Workmen's Compensation Has Been or Is Being Paid.**—If at the time the patient's bill is sub-

mitted, workmen's compensation payment has been or is being made which fully covers the cost of the items and services furnished, no payment under the health insurance program may be made.

A lump sum compromise awarded as payment of a workmen's compensation claim may include an amount for medical, hospital, and posthospital expenses. The payment under health insurance in such cases is based on the intermediary's judgment as to what could reasonably have been expected to be paid for these services under workmen's compensation had the individual pursued his rights rather than accepting the amount of the compromise settlement.

The facility will be notified by the intermediary of the extent to which its bill was covered by workmen's compensation.

**B. Workmen's Compensation is Reasonably Expected.**—If, at the time the facility submits its bill, workmen's compensation has not been or is not being paid, the intermediary will determine whether workmen's compensation can reasonably be expected to pay for the items and services covered by the bill. Should the intermediary determine that there is a reasonable expectation that workmen's compensation payment will be made for the patient's care, the facility will be notified that health insurance payments may not be made due to the expectation of workmen's compensation coverage. The individual will also be notified of the intermediary's decision. In the event that workmen's compensation does not ultimately pay for the services, the claim under health insurance may be reopened.

**C. Workmen's Compensation is Questionable.**—Should the intermediary determine that workmen's compensation payments cannot reasonably be expected, payment under health insurance may be made to the facility on condition that such payment will be refunded in the event workmen's compensation later pays for the services. However, conditional payment will not be made unless there is a real question as to whether payment will be made by workmen's compensation. The mere fact that the employer or workmen's compensation carrier is contesting liability would not in itself be a sufficient basis to warrant conditional payment.

**258.3 Overpayments.**—If the facility receives workmen's compensation payments after having received health insurance payments for the same items and services, the program must be reimbursed for such overpayment. The facility may arrange with the intermediary to accomplish this by direct refund or adjustment of future program payments to the facility.



## 260. UTILIZATION REVIEW PLAN

A participating extended care facility is required to have in effect a plan for utilization review which applies to the inpatient services the facility furnishes to patients entitled to benefits under the health insurance program. The plan must provide for review on a sample or other basis, of admissions, duration of stays, and professional services furnished; and review of each case of continuous extended duration while the patient is in the facility. The detailed requirements for an acceptable utilization review plan are set out in § XVIII of the "Conditions of Participation for Extended Care Facilities" (HIM-3). Payments made to physicians serving on extended care facility utilization review committees will be considered as an allowable cost without regard to whether the facility's plan is applicable solely to medicare beneficiaries or to all patients of the facility.

**260.1 Definition of Extended Stay—Beneficiary Admitted Before January 1, 1967.**—The rules for the review of extended-stay cases are explained in § XVIII of the "Conditions of Participation for Extended Care Facilities" (HIM-3).

Generally, in determining when a case is subject to review as an extended stay case, the counting of days begins with the date of admission. However, a patient who is entitled to benefits as of January 1, 1967, i.e., is age 65 and has met the prior hospitalization and transfer requirements, is considered to have been admitted on January 1, 1967, if he is in a participating facility on that date.

**260.2 Further Inpatient Stay Not Medically Necessary.**—If in the review of an extended-stay case the physician members of the utilization review committee decide, after opportunity for consultation is given the attending physician, and after considering the availability and appropriateness of outside facilities and services, that further inpatient stay is not medically necessary, notification in writing of this decision must be given within 48 hours to the institution, the attending physician, and the patient. However, where the committee approves a request by the attending physician that he be permitted to notify the patient of the committee's decision, such notice will constitute proper notification to the patient. Payment cannot be made for more than 3 days of extended care services after the date the notice is received by the facility.

**260.3 Failure To Make Timely Review of Cases.**—If the Social Security Administration determines on the basis of information obtained by a State agency or by an intermediary during the course of its

ongoing review of utilization practices, that a facility has substantially failed to make timely review of long-stay cases, it may, in lieu of terminating its agreement with the facility, limit payment to the institution to no more than 20 consecutive days of extended care services furnished a beneficiary. This limitation would be applicable to beneficiaries admitted to the institution after an effective date specified in the written notice of the imposition of the restriction to be given to the facility, the public, and the hospital with which the facility has a transfer agreement.

The limitation will be removed when it is determined that timely review of long-stay cases has been restored and there is reasonable assurance that the deficiency will not recur.

## Appeals of Payment Determinations

### 270. EXTENDED CARE FACILITY PROTEST OF PAYMENT DETERMINATION

The extended care facility and its intermediary should attempt to resolve mutually any differences involving payment for services that arise from the application of the cost formula or the amount payable in a specific case. While no appeal is available for facilities or other providers from intermediary determinations involving payments, provider complaints and protests will be considered in Social Security Administration review of the intermediary's application of the cost formula or its compliance with the other terms of its agreement with the Government.

### 273. BENEFICIARY PROTESTS AND APPEALS OF PAYMENT DETERMINATIONS

**A. Hospital Insurance Program.**—An individual dissatisfied with any determination of the amount of benefits payable on his behalf under hospital insurance may have his claim reconsidered by the Social Security Administration. If he is not satisfied with the reconsideration determination and the amount in controversy is \$100 or more, he may request a hearing by the Social Security Administration. If the amount in controversy is \$1,000 or more and he is dissatisfied with the hearing decision, the individual may initiate action for Federal court review of the claim.

**B. Medical Insurance Program.**—An individual dissatisfied with denial of a request for payment of medical insurance benefits, or with the amount of medical insurance benefits paid, or with the promptness with which his request for payment is acted upon is entitled to an opportunity for a review by, and if still

dissatisfied, to a fair hearing by the medical insurance intermediary.

A patient dissatisfied with a payment for the services of a facility-based physician is entitled to a review by and, if still dissatisfied, to a fair hearing by the medical insurance intermediary to whom the bill for the physician's services was submitted for payment.

C. **Patient protests** concerning charges for items or services furnished by the extended care facility should be handled, if simply amenable to explanation

or correction, by the facility. If the patient wishes to protest the health insurance determination on his request for payment or the promptness of payment, he should be referred to his social security district office. The district office can offer assistance to the beneficiary in determining his appeal rights and can answer specific questions about the appeal procedures. The district office can also assist the individual in completing the necessary forms for requesting reconsideration or hearing.





### Chapter III

## ADMISSION PROCEDURES

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## Chapter III

### ADMISSION PROCEDURES

#### 300. SUMMARY OF ADMISSION PROCEDURES

Upon the admission of a medicare beneficiary, or as soon thereafter as practicable, the participating extended care facility should:

- a. Obtain the patient's signed request for payment. (See §§ 250ff.)
- b. Complete the admission notice (see §§ 303 and 303.1) and send the information to the intermediary, or to the social security district office if the facility deals directly with the Social Security Administration.
- c. Obtain the physician's certification concerning the need for extended care services. (See §§ 252ff.)

In reply to the facility's admission notice, the intermediary will send a report of eligibility. This will show the patient's remaining days of eligibility and other data needed to complete the billing form. If the facility deals directly with the Social Security Administration, a Reply to the Notice of Admission (Form SSA-1568) will be sent from the Bureau of Health Insurance, Direct Reimbursement Branch, Baltimore, Maryland.

Detailed instructions for completing the admission notice are given in the following sections.

#### 301. 3-DAY HOSPITAL STAY AND 14-DAY TRANSFER REQUIREMENTS

As explained in § 211, a beneficiary must meet the prior hospital stay and transfer requirements to have extended care facility benefits paid on his behalf. The intermediary will determine at the time it forwards the report of eligibility to the extended care facility whether these requirements are met. The intermediary will rely on the information given in items 5, 9, and 11 of the Extended Care Admission and Billing (Form SSA-1478), whenever possible.

The prior-stay hospital will usually send a patient transfer form to the extended care facility, in accordance with their transfer agreement. When the facility has in its files a transfer form showing the hospital admission and discharge dates, or a written record of a telephone conversation with the transferring hospital in which this information was given, it should record

these dates in item 5 of the form SSA-1478. Otherwise, this item should be left blank to alert the intermediary to take necessary action to verify the prior-stay information.

In item 9 of the form SSA-1478, the facility should enter the actual date of admission to the facility, even though this was before January 1, 1967. Extended care facility benefits may be payable on behalf of beneficiaries effective January 1, 1967, even though they were admitted to the facility before that date. (See § 211.3.) Full details concerning the prior hospital stay dates and extended care facility stay or stays after June 30, 1966, and prior to January 1, 1967, should be given, so that the intermediary can determine whether the 3-day stay and 14-day transfer requirements were met. If additional space is required, attach a statement to the admission notice.

In item 11, the first entry should be the name and address of the 3-day prior stay hospital. If an intervening extended care facility stay or stays, or an intervening hospital stay of less than 3 days, occurred between the hospital discharge and the current extended care facility admission, the names and addresses of such intervening facilities or hospitals, participating or non-participating, should also be entered in item 11, or on a statement attached to the admission notice. (See § 303.2.)

#### 302. OBTAINING THE HEALTH INSURANCE CLAIM NUMBER

It is very important that the patient's health insurance claim number be accurately recorded on the admission and billing forms because the case cannot be processed if this number is missing or incorrect.

The Social Security Administration maintains in Baltimore, Maryland, the records of all persons entitled to health insurance. After entitlement is established, each beneficiary is issued a health insurance card by the central office of the Social Security Administration (or in some cases by the Railroad Retirement Board) for use in obtaining hospital insurance benefits, medical insurance benefits, or both. The health insurance claim number on the card is essential for locating the patient's



record when a claim for benefit payment is made. **No admission notice or billing form should be forwarded without the correct claim number.** Exhibit 1 of this chapter shows the health insurance cards and briefly explains the numbering system as an aid in recognizing valid numbers.

Usually, the patient's health insurance claim number will be shown on the hospital transfer form. If it is not, the facility should ask the patient for his health insurance card, Temporary Eligibility Notice (see § 302.3), or other notice the patient has received from the Social Security Administration or an intermediary which shows his health insurance claim number. If the patient cannot furnish his claim number, the facility should get in touch with the transferring hospital, if it is a participating hospital, for the claim number shown on the hospital's billing form.

If the patient's health insurance claim number cannot be obtained from the above sources, the facility should request it from the SSA district office. (In addition to determining correct claim numbers, the district office can help a beneficiary replace a lost health insurance card.)

**302.1 Information Required By SSA District Office.**—If the patient's social security account number is available, the district office will usually require no additional information to locate the claim number or determine that the patient has not established health insurance entitlement.

If the patient has ever been employed or self-employed, or sought employment, or filed Federal Income Tax Returns, he should have a social security card. This card contains his social security account number which consists of 9 digits, 000-00-0000, but does not have the letter prefix or suffix which distinguishes the health insurance claim number. (See Exhibit 1.)

**A social security account number is not sufficient for processing a claim.**

If the account number is not available, the following information should be furnished:

a. The patient's name and statement as to whether or not he ever applied for social security monthly benefits, railroad retirement benefits, or for hospital insurance benefits;

b. If the patient says he applied, the name of the person on whose social security account the application was based, e.g., his own account or the account of a husband or a wife;

c. The patient's father's full name, mother's maiden name, and the patient's date and place of birth;

d. Patient's address.

If the facility cannot give all the identifying information required from the beneficiary, it should furnish as much as it has to the SSA district office.

**302.2 The SSA District Office Reply.**—The SSA district office will respond as soon as possible. If the claim number is not available, the district office will inform the facility of the action it is taking, i.e., that a claim number has been requested from SSA central records, or that it is developing an application, or an application is pending.

If an application for hospital insurance benefits is taken as a result of the request to the district office for a claim number, or is pending when the facility requests a claim number, the district office will inform the facility when processing is completed and give the facility the claim number. The facility may then send the notice of admission information to the intermediary (or to the district office if the facility deals directly with SSA).

**302.3 Temporary Eligibility Notice.**—The social security district office may under certain circumstances issue a temporary health insurance eligibility notice, pending the issuance of a health insurance card, when the beneficiary is in need of medical services. (See Exhibit 2.) The patient's name and health insurance claim number on the temporary eligibility notice should be entered on the admission notice. The intermediary will use that information for checking the Social Security Administration central record and for replying to the extended care facility about the patient's days of eligibility and deductible status.

**302.4 Intermediary Requests for Verification of Health Insurance Claim Number.**—If the name and health insurance claim number shown on the admission notice do not agree with the information shown on the SSA central beneficiary record, the admission notice will be rejected and returned to the intermediary. The intermediary will then ask the extended care facility to check its records, and check with the patient if that is feasible, for correct name and claim number information.

If unable to get corrected information from these sources, the facility should inform the social security district office that an admission notice was rejected because of incorrect name and claim number information. The district office will investigate and give the correct name and claim number to the facility, or confirm that the individual is not entitled to health insurance and has no claim number, if that is the case. The facility should report the information received from the district office to the intermediary.

### 303. ADMISSION NOTICE

A participating hospital can receive payments for a specified number of days under the hospital insurance program for inpatient services furnished a beneficiary in good faith during the period preceding receipt of the intermediary's report of eligibility, even though that report shows that as of the time of its receipt by the hospital the beneficiary's entitlement to inpatient hospital services has been exhausted for the current spell of illness. **HOWEVER, THERE IS NO SUCH GUARANTEE OF PAYMENT PROVISION IN THE LAW FOR EXTENDED CARE FACILITIES.** It is important that the extended care facility admission notice be sent as soon as possible, so that a speedy report on the patient's eligibility may be given to the facility.

The admission notice (see Exhibit 3) data sent to the intermediary should include the information called for in items 1 through 14 of the form SSA-1478; except that where item 12 applies, its completion may be delayed until the bill is submitted. The bottom two copies of the form SSA-1478 are the admission notice copies. Depending on the arrangements made with the intermediary or the social security district office, the facility may send the admission notice copies of the billing form by mail or messenger, or may submit the information from these forms by wire or telephone.

**303.1 Completing Admission Notices.**—The hospital transfer form should show the patient's name and address; health insurance claim number; dates of hospital stay; welfare agency name, address, and case number, if applicable; and a notation indicating workmen's compensation, if any. The facility should rely on this information in completing items 1, 2, 3, 5, 10, 11, and 14 of the form SSA-1478. (Additional information from the patient or hospital may be required to complete items 10 and 11.)

All entries on the form should be typed. Show month, day, and year entries in 6-digit numbers, e.g., 07/09/67.

#### 303.2 Explanation of Admission Notice Entries

**Item 1. Patient's Name.**—The patient's name should be the same as that shown on the hospital transfer form or on his health insurance card, with the last name first.

**Item 2. Health Insurance Claim Number.**—Enter the health insurance claim number as shown on the hospital transfer form, the patient's health insurance card, utilization notices, the temporary eligibility notice, or as reported by the social security district office.

**Item 3. Patient's Address.**—Enter the patient's mailing address.

**Item 4. Attending Physician.**—Enter the name of the physician who is expected to certify the medical necessity of the extended care facility stay.

**Item 5. Dates of Prior Hospital Stay.**—Enter the dates of stay in the hospital from which the patient was most recently discharged. If the facility does not have in its files a hospital transfer form showing these dates, or a written report of a telephone conversation with the hospital in which these dates were furnished, then the facility should not complete item 5. The transferring hospital's name and address should be shown in item 11, and the intermediary will verify the prior-stay dates and enter them on the billing form.

**Items 6 and 7. Provider Identification and Provider Number.**—Enter the name and address of the extended care facility and the assigned health insurance provider number. This information may be pre-printed or stamped on all copies of the form, if desired.

**Item 8. Medical Record Number.**—Enter the number, if any, used by the facility to identify the patient's medical record.

**Item 9. Date of Admission.**—Enter the date of the current admission in 6-digit numbers; e.g., 09/07/67. Show the actual date of admission even though this was before January 1, 1967.

**Item 10. Payment Source.**—Indicate who will pay for any services to the patient which will not be paid for by the health insurance program. More than one source may be checked, if applicable. If State public welfare agency payments will be made, show the name and address of the agency and the patient's case number, if known.

**Item 11. Names and Addresses of Prior-Stay Institutions.**—Enter **first** the name and address of the hospital from which the patient was most recently discharged, after a stay of at least 3 days. The first entry in item 11 should always be the name and address of the hospital to which item 5 refers.

Next enter the name and address of any extended care facility the patient entered in the period between his discharge from the hospital item 5 refers to, and his current facility admission. Also, enter the name and address of any hospital the patient may have entered in this period for a stay of less than 3 days.

The last entries in item 11 should be the names and addresses of any hospital or extended care facility (not already listed) from which the patient was discharged in the 60-day period before the current extended care facility admission. This information is needed by the



intermediary to determine the number of inpatient extended care facility benefit days for which the patient is eligible in the current spell of illness.

Prior-stay institutions should be listed in this item regardless of whether they are participating in the health insurance program.

**Item 12. If the Patient Received Accommodations Other Than Semi-private, Explain the Reason Why.**—This item needs to be completed only if the patient is being assigned to accommodations other than semi-private. If item 12 is not completed at the time of admission, and other than semi-private accommodations are furnished at a later date, item 12 should be completed when the bill is submitted.

If the patient is furnished private accommodations, check the appropriate block indicating the reason for this (patient's request, medical necessity, other reason). If the "medical necessity" or "other reason" block is checked, type a brief explanation in this item.

If private accommodations were medically necessary, the program will pay the reasonable cost of these accommodations. If a private room was furnished at the patient's request, the program will cover only the cost of a semi-private room, and the patient is responsible for the difference between the customary private room charges, and the most prevalent customary semi-private room charges at the time of admission. If the patient was furnished a private room and this was not at his request nor medically necessary, the program will pay only the cost of the most prevalent semi-private accommodations at that time; **and** the patient may not be charged any additional amount. (See § 212.2.A and B.)

If the patient requested a private room, show the most prevalent charge for semi-private accommodations in item 12.

If the patient is furnished ward accommodations, check the appropriate block indicating whether this was done at the patient's request or for another reason. If the "other reason" block is checked, type a brief explanation in this item. Then enter, in the space provided, the amount representing the most prevalent charge for semi-private accommodations in the facility at the time of admission. If the patient is assigned to a ward, and this was not at his request nor for a reason which the intermediary determines is consistent with program purposes, reimbursement to the facility will be based on the cost of semi-private accommodations minus the difference between the customary semi-private charges at the most prevalent rate and customary ward charges. (See § 212.C.)

To determine the most prevalent charge for semi-private accommodations:

- (1) Type of accommodation.
- (2) Total rooms of each type for each different room rate.
- (3) Total beds found in each type for each room rate.
- (4) Rate you charge daily for the type of room.
- (5) Your most prevalent charge for semi-private accommodations is that single rate that you charge for the largest entry appearing under your "total beds" column.

**Example:**

(1) Type of accommodation	(2) Total rooms of this type	(3) Total beds col. (1) x col. (2)	(4) Rate per day
2 beds.....	10	20	\$14.00
2 beds.....	8	16	15.00
3 beds.....	2	6	12.00
4 beds.....	1	4	9.00

*Note:* \$14.00 is the most prevalent semi-private charge.

**Item 13. Patient's Certification and Payment Request.**—Have the patient or his authorized representative read the statement on the form or the statement in the facility's admission record if the facility uses the alternate signature procedure (see § 250.2). If the facility obtains the signature on its own form, the signature line of the original of form SSA-1478 should be stamped to indicate that the "Patient's request for payment is on file." If the signature is obtained on form SSA-1478, it is sufficient if it is legible on the original only.

If the patient cannot sign his name because of his physical or mental condition, another person may sign on his behalf; e.g., John J. Jones by Jack A. Smith. In certain situations, a facility representative may sign on behalf of the patient. (See § 251 for who may file a payment request.)

Briefly explain the reason why the patient did not sign the form himself and show the relationship of the signer to the patient. This explanation should be retained in the facility's file if the signature is obtained on the facility's own record. If the signature is on form SSA-1478, the explanation should accompany or be included on the billing form.

The statement should be read to the patient who signs by mark. The signature by mark should be witnessed by a person who knows the patient. Enter the name



and address of any person witnessing the signature by mark.

**Item 14. Admitting Diagnoses.**—Enter the primary and secondary diagnoses. The physician's certification will indicate that inpatient extended care services are required for a condition for which the patient was receiving inpatient hospital services. Use standard nomenclature from "Standard Nomenclature of Diseases and Operations," "Current Medical Terminology, Surgical Section," and "Current Procedural Terminology."

Check the appropriate block indicating whether a workmen's compensation claim is involved. (See § 258.)

### 304. REPLY TO NOTICE OF ADMISSION

The bottom portions of the admission copies of form SSA-1478 are designed to provide eligibility information in response to the extended care facility admission notices. (See Exhibit 3.) The intermediary may use the form for this purpose, or may give the eligibility information to the facility by wire or telephone, depending upon the arrangements made between the facility and the intermediary. The direct-dealing extended care facility will receive a form reply (form SSA-1568) to the Notice of Admission from Bureau of Health Insurance, Direct Reimbursement Branch, Baltimore, Maryland.

Whether the reply is given by mail, telephone, or wire to the facility, it will contain the following eligibility information called for on the "Report of Eligibility" portion of the admission notice:

**A. Effective Date—Hospital Insurance.**—The month and year of the patient's entitlement to hospital insurance benefits (Part A) will be shown. If not entitled, the entry will so indicate.

**B. Effective Date—Medical Insurance.**—This will show the month and year of the patient's entitlement to medical insurance (Part B). The entry will so indicate if the patient is not entitled to Part B benefits.

**C. ECF Days Remaining.**—The number of extended care facility days for which payment can be made in full for the current spell of illness will be shown in the "Full" block. The number of days remaining, for which the patient must pay the coinsurance amount, will be shown in the "Coinsurance" block. "None" will be shown where applicable.

**D. Pints Remaining—Blood Deductible.**—This item is for informational purposes.

**E. 3-Day Hospital Stay Requirement.**—The intermediary will complete this item to show whether this requirement is "Met" or "Not Met."

**F. 14-Day Transfer Requirement.**—The intermediary will complete this item to show whether the 14-day requirement is "Met" or "Not Met."

**G. HHA Visits Remaining—Hospital Insurance and Medical Insurance.**—The number of home health visits remaining under Part A will be shown. Remaining home health visits under Part B will not be routinely shown in replying to extended care facility Notices of Admission.

**H. Medical Plan Deductible.**—The status of this deductible will be indicated by a checkmark in the block designated "Met" or "Not Met." If the deductible is not met, the amount remaining to be met will not be shown. If the reply shows the deductible is "Not Met," and Part B services have been furnished, the extended care facility should ask the patient whether he has had any previous Part B expenses which could be counted toward the deductible. (See § 115.3.) The facility should try to determine whether the patient has satisfied the Part B deductible before charging him this amount.

The intermediary will determine the patient's exact Part B deductible status upon receipt of the facility's bill.

**I. Open Item Information.**—The information in this block will be completed by the intermediary when verifying reports of "extended care facility open items" (admissions recorded in SSA central records, but not closed out by processing of a bill).

Where there is an extended care facility open item reported from the SSA central record, this "open item" must be processed before the current bill can be processed. The intermediary (or the SSA Direct Reimbursement Branch in the case of a direct-dealing provider) will get in touch with the "open item" provider to verify the stay, the date of the prior discharge, and status of the bill. The intermediary will use the prior stay information to compute the remaining days of eligibility.

**Remarks.**—Any necessary explanation of eligibility information will be shown. This will include corrections in the name or health insurance claim number reported by the facility. When changes of this sort are reported, the name and claim number information on the billing form should be changed accordingly.

If name and claim number information were not matched, the intermediary will request the facility to verify the claim number. (See § 302.4.)

### 305. RETROACTIVE ENTITLEMENT

It may happen that an individual over 65 years of age does not establish his entitlement to hospital insurance benefits until after his discharge from an ex-

tended care facility. In such a case, payment may be made for extended care service furnished in a retroactive period of up to 12 months, but not before January 1, 1967. When a beneficiary inquires about retroactive entitlement, he will usually have a Social Security Administration notice which prompted his inquiry. In these cases, the facility should follow the Notice of Admission procedure to verify the patient's eligibility. When this is verified, the facility should refund to the patient any payments he made for services which are covered by the program, and submit a bill to the intermediary.

### **306. INITIATING NOTICES OF ADMISSION WHERE NO PAYMENT WILL BE MADE**

§ 405 explains that extended care facilities will submit billing forms even when no payments under the program may be made. In most such cases, Notices of Admission will have been initiated as a normal course of procedure to determine the patient's eligibility. However, there will be some situations where, at admission, the individual states that benefits have been exhausted in the current spell of illness. The extended care facility should nevertheless initiate a Notice of Admission. This notice will serve to verify that the

patient has in fact no remaining eligibility, and also help to keep the beneficiary's utilization record current.

Notices of Admission should also be sent even though workmen's compensation has paid or can be expected to pay the entire bill, the services are not covered, the 3-day hospital stay and 14-day transfer requirement are not met, or the patient refuses to request payment.

Where the patient refuses to request payment and does not furnish his health insurance claim number, the facility should get in touch with the SSA district office for assistance in obtaining this number. If the patient refuses to request payment which could otherwise be made on his behalf, his utilization record must nevertheless be charged for covered extended care services furnished him.

After the report of eligibility is received in such no-payment cases, billing forms should be forwarded, to keep the patient's utilization record current, in accordance with § 405.

### **399. EXHIBITS**

Exhibit 1. Health Insurance Cards and Claim Numbers

Exhibit 2. Temporary Eligibility Notice

Exhibit 3. Extended Care Admission and Billing (Admission Copy)—Form SSA-1478

# EXHIBIT I

## HEALTH INSURANCE CARDS

Health Insurance	
SOCIAL SECURITY ACT	
NAME OF BENEFICIARY <b>JANE Q. DOE</b>	
CLAIM NUMBER <b>000-00-0000B</b>	SEX <b>FEMALE</b>
IS ENTITLED TO	
HOSPITAL INSURANCE	<b>7-1-66</b>
MEDICAL INSURANCE	<b>7-1-66</b>
SIGN HERE	

Front

1. Carry your card with you when you are away from home.
2. Let your hospital or doctor see your card when you require hospital, medical or health services under "Medicare."
3. Get in touch with your social security office if you have questions about your rights under "Medicare."
4. Your card is good wherever you live in the United States.

WARNING: Issued for the sole use of the holder designated hereon. Intentional misuse of this card is unlawful and will make the offender liable to penalty.

PROPERTY OF UNITED STATES GOVERNMENT.  
IF FOUND DROP IN NEAREST U.S. MAIL BOX.

Return To: SOCIAL SECURITY ADMINISTRATION  
Baltimore, Maryland 21235

FORM SSA-1966 (7-66)

Back

Health Insurance	
RAILROAD RETIREMENT BOARD	
NAME OF BENEFICIARY <b>JOHN C. DOE</b>	
CLAIM NUMBER <b>A-000-00-0000</b>	SEX <b>MALE</b>
IS ENTITLED TO	
HOSPITAL INSURANCE	<b>7-1-66</b>
MEDICAL INSURANCE	<b>7-1-66</b>
SIGN HERE	

Front

1. Carry your card with you when you are away from home.
2. Let your hospital or doctor see your card when you require hospital, medical or health services under "Medicare."
3. Get in touch with your Railroad Retirement Board office if you have questions about your rights under "Medicare."
4. Your card is good wherever you live in the United States. For benefits in Canada, write to the Railroad Retirement Board.

WARNING: Issued for the sole use of the holder designated hereon. Intentional misuse of this card is unlawful and will make the offender liable to penalty.

PROPERTY OF UNITED STATES GOVERNMENT.  
IF FOUND DROP IN NEAREST U.S. MAIL BOX.

Return to: RAILROAD RETIREMENT BOARD  
844 Rush Street, Chicago, Illinois 60611

Form G-43 (2-66)

Back

## HEALTH INSURANCE CLAIM NUMBERS

Most HI claim numbers are 9 digits with a letter or letter and numeral suffix; e.g., 000-00-0000B or B1. They may also be 6-or-9-digit numbers with lettered prefixes; e.g., A000000, A-000-00-0000; or WD-000000, WD-000-00-0000. Numbers with one or more letter prefixes identify Railroad Retirement Board annuitants.

Possible suffixes are:

A, B, B1, B2, B3, B4, B5, B6, or B9

C1, C2, C3, C4, C5, C6, C7, C8, or C9

D, D1, D2, D3, D4, D5, D6, or D7

E, E1, E2, or E3

F1, F2, F3, F4, F5, F6, F7, or F8

HB, HB1, HB2, HB3, HB4, HB5, HB6, or HB9

HC1, HC2, HC3, HC4, HC5, HC6, HC7, HC8, or HC9

J1, J2, J3, J4 (For subscripts "3" and "4" there can be no entitlement to hospital insurance benefits.)

K1, K2, K3, K4 (Supplementary medical insurance entitlement may exist for all J and K suffixes.)

M, M1, and T (Suffix letter "T" indicates entitlement to hospital or hospital and medical insurance; letters M and M1 indicate that the patient is eligible for supplementary medical insurance benefits but not for hospital insurance benefits.)





EXHIBIT 2

TEMPORARY NOTICE OF ELIGIBILITY

District Office Address:

Date:

Dear \_\_\_\_\_:

Based on the information you have given to the Social Security Administration you will be eligible for hospital insurance benefits beginning (mo.) \_\_\_\_\_ (yr.) \_\_\_\_\_ and for supplementary medical insurance benefits beginning (mo.) \_\_\_\_\_ (yr.) \_\_\_\_\_. Your eligibility will continue for 60 days from the date shown at the top of this notice unless you are notified otherwise during the 60-day period.

To obtain medical services before you receive your card, show this letter to your hospital or doctor but keep the letter with you. This temporary notice of eligibility is to be used only by the person to whom it is addressed. Misuse is unlawful and will make the offender liable to a penalty.

This letter should be destroyed as soon as you receive your health insurance card or other notice concerning your eligibility.

Sincerely yours,

Robert M. Ball  
Commissioner of Social Security

IMPORTANT


When services are provided on the basis of this notice, all bills or correspondence with an intermediary or the Social Security Administration should show the patient's social security claim number.





## EXHIBIT 3

## EXTENDED CARE ADMISSION AND BILLING

 DEPARTMENT OF HEALTH, EDUCATION, AND WELFARE SOCIAL SECURITY ADMINISTRATION		<b>EXTENDED CARE ADMISSION AND BILLING</b> <b>HOSPITAL INSURANCE BENEFITS - SOCIAL SECURITY ACT</b>		Form Approved Budget Bureau No. 72-R765	
1. PATIENT'S LAST NAME		FIRST NAME		2. HEALTH INSURANCE CLAIM NUMBER	
3. PATIENT'S ADDRESS (Street number, City, State, Zip Code)				4. NAME OF ATTENDING PHYSICIAN	
5. DATES OF PRIOR HOSPITAL STAY		6. EXTENDED CARE FACILITY NAME AND ADDRESS		7. PROVIDER NUMBER	
ADMISSION      DISCHARGE				8. MEDICAL RECORD NO.	
9. DATE OF THIS ADMISSION		10. PAYMENT SOURCE FOR CHARGES TO PATIENT			
		<input type="checkbox"/> SELF OR FAMILY <input type="checkbox"/> BLUE CROSS BLUE SHIELD <input type="checkbox"/> PUBLIC AGENCY (Give name) <input type="checkbox"/> PRIVATE INSURANCE <input type="checkbox"/> EMPLOYER OR UNION <input type="checkbox"/> OTHER (Explain)			
11. NAMES AND ADDRESSES OF ALL HOSPITALS AND EXTENDED CARE FACILITIES FROM WHICH PATIENT WAS DISCHARGED IN PAST 60 DAYS. (If this ECF, give dates of stay).					
12. REASON FOR OTHER THAN SEMI-PRIVATE ACCOMMODATIONS: <input type="checkbox"/> PATIENT'S REQUEST <input type="checkbox"/> MEDICAL NECESSITY (Describe) <input type="checkbox"/> OTHER REASON (Specify)					
Most Prevalent Semi-Private Rate \$ _____					
13. PATIENT'S CERTIFICATION, AUTHORIZATION TO RELEASE INFORMATION, AND PAYMENT REQUEST. I certify that the information given by me in applying for payment under Title XVIII of the Social Security Act is correct. I authorize release of all records required to act on this request. I request that payment of authorized benefits be made on my behalf.					
SIGNATURE (Patient or authorized representative) (Signature by mark must be witnessed)				DATE	
14. ADMITTING DIAGNOSES		EMPLOYMENT RELATED <input type="checkbox"/> YES <input type="checkbox"/> NO		DO NOT USE THIS SPACE     	
(a) Primary					
(b) Secondary					
<b>REPORT OF ELIGIBILITY</b>					
A. Effective Date—Hospital Insurance				I. Open Item Information 1. Intermediary	
B. Effective Date—Medical Insurance					
C. ECF days remaining		FULL      COINSURANCE		2. Provider	
D. Pints remaining blood deductible					
E. 3 day hospital stay requirement		<input type="checkbox"/> MET <input type="checkbox"/> NOT MET		3. Date Admitted	
F. 14 days transfer requirement		<input type="checkbox"/> MET <input type="checkbox"/> NOT MET			
G. HHA visits remaining		HOSPITAL INS.    MEDICAL INS.		4. Date Discharged	
H. Medical plan deductible		<input type="checkbox"/> MET <input type="checkbox"/> NOT MET			
REMARKS					
INTERMEDIARY APPROVAL				DATE	



## Chapter IV

### BILLING PROCEDURES

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EXTENDED CARE ADMISSION AND BILLING  
HOSPITAL INSURANCE BENEFITS - SOCIAL SECURITY ACTForm Approved  
Budget Bureau No. 72-R765

1. PATIENT'S LAST NAME		FIRST NAME		MI	2. HEALTH INSURANCE CLAIM NUMBER	
3. PATIENT'S ADDRESS (Street number, City, State, Zip Code)					4. NAME OF ATTENDING PHYSICIAN	
5. DATES OF PRIOR HOSPITAL STAY ADMISSION      DISCHARGE		6. EXTENDED CARE FACILITY NAME AND ADDRESS			7. PROVIDER NUMBER	
9. DATE OF THIS ADMISSION					8. MEDICAL RECORD NO.	
		10. PAYMENT SOURCE FOR CHARGES TO PATIENT <input type="checkbox"/> SELF OR FAMILY <input type="checkbox"/> BLUE CROSS BLUE SHIELD <input type="checkbox"/> PUBLIC AGENCY (Give name) <input type="checkbox"/> PRIVATE INSURANCE <input type="checkbox"/> EMPLOYER OR UNION <input type="checkbox"/> OTHER (Explain)				
11. NAMES AND ADDRESSES OF ALL HOSPITALS AND EXTENDED CARE FACILITIES FROM WHICH PATIENT WAS DISCHARGED IN PAST 60 DAYS. (If this ECF, give dates of stay).						
12. REASON FOR OTHER THAN SEMI-PRIVATE ACCOMMODATIONS: <input type="checkbox"/> PATIENT'S REQUEST <input type="checkbox"/> MEDICAL NECESSITY (Describe) <input type="checkbox"/> OTHER REASON (Specify)						
Most Prevalent Semi-Private Rate \$						
13. PATIENT'S CERTIFICATION, AUTHORIZATION TO RELEASE INFORMATION, AND PAYMENT REQUEST. I certify that the information given by me in applying for payment under Title XVIII of the Social Security Act is correct. I authorize release of all records required to act on this request. I request that payment of authorized benefits be made on my behalf.						
SIGNATURE (Patient or authorized representative) (Signature by mark must be witnessed)					DATE	
14. ADMITTING DIAGNOSES		EMPLOYMENT RELATED <input type="checkbox"/> YES <input type="checkbox"/> NO			DO NOT USE THIS SPACE	
(a) Primary						
(b) Secondary						
15. DISCHARGE OR CURRENT DIAGNOSES						
(a) Primary						
(b) Secondary						
16. STATEMENT OF SERVICES RENDERED			TOTAL INPATIENT CHARGES	NON-COVERED CHARGES	20. STATEMENT COVERS PERIOD FROM      THRU	
ACCOMMODATIONS	DAYS	RATE				
A. 1-Bed					22. DATE UR NOTICE RECEIVED	
B. 2-3-4 Bed					23. DATE BENEFITS EXHAUSTED	
C. 5 or more beds					24. TOTAL DAYS	
D. Physical Therapy					25. <input type="checkbox"/> DISCHARGED <input type="checkbox"/> DIED <input type="checkbox"/> STILL PATIENT	
E. Occupational Therapy					26. DATE DISCHARGED OR DIED	
F. Speech Therapy					27. COMPUTATION OF INTERIM PAYMENT	
G. Pharmacy						
H. Other (Describe)						
I. TOTALS			\$			
17. Coinsurance      Days@			\$	Reimbursement Amount \$		
18. Part B Services Furnished to other than Inpatients			CHARGES	INTERMEDIARY USE		
			\$	VERIFIED PRIOR STAY DATES		
				28. QUALIFYING HOSPITAL BEGINNING THRU		
				PROVIDER NUMBER		
TOTALS				28a. OTHER		
19. Part B Charges paid by Patient			\$	29. SEMI-PRIVATE DIFFERENTIAL \$		
32. I certify that the required Physician's certification and recertifications are on file.				30. PART B DEDUCTIBLE \$		
SIGNATURE OF EXTENDED CARE FACILITY REPRESENTATIVE			DATE FWD.	30a. COINSURANCE \$		
				31. REFUND TO PATIENT \$		
				33. APPROVED BY		
				DATE		

## Chapter IV

### BILLING PROCEDURES

#### 400. SUMMARY OF BILLING PROCEDURES

The Extended Care Admission and Billing Form SSA-1478 was designed for extended care facility billing for services reimbursable under the program on a reasonable cost basis. A facility should use Form SSA-1554, Provider Billing For Patient Services By Physicians, to bill for reasonable charge reimbursement for facility-based physician services to patients. (See § 215 for definition.) The Form SSA-1478 will be processed by the Part A intermediary, and the Form SSA-1554 will be processed by the Part B intermediary.

The upper section of the SSA-1478 (items 1 through 14) should be completed on all six copies at the time of admission. The lower or billing section of the form (items 15 through 32) should be completed when the patient is discharged or when his benefits are exhausted, whichever occurs first. (It is not necessary to submit a billing form each time a patient has a leave of absence.) The benefit status data needed to complete the form will be given in the SSA reply to the notice of admission. The billing copies of the form should then be sent to the intermediary (or to the Social Security Administration if the facility deals direct).

The bill may also be submitted on an interim basis, for example, every 30 days. The admission notice need not be completed for subsequent billings for the same extended care facility stay, and the patient's signature is not needed for such subsequent billings.

A billing form should be submitted, even though no benefits may be payable, to enable the Social Security Administration to keep the patient's utilization record current (see § 405), and to close out the admission notice sent in "no-payment" cases.

#### 401. LIST OF AUTHORIZED SIGNATORIES

Each extended care facility should submit to its Part A intermediary a listing of officials it has authorized to sign and certify bills and supporting statements. The listing should be kept current.

#### 402. COMPLETION OF BILLING ITEMS ON FORM SSA-1478

*Item 15. Discharge or Current Diagnoses.*—If this is an interim bill the current diagnoses should be shown.

The primary diagnosis should appear first. Then list any secondary diagnoses. Standard nomenclature should be used (refer to "Standard Nomenclature of Diseases and Operations," "Current Medical Terminology," and "Current Procedural Terminology").

*Item 16. Statement of Services Rendered.*—Enter all charges by each department for the period covered by the current billing. Where the facility has more departments than those shown on the form, combine the charges, where appropriate. Any charge which cannot be applied to one of the items shown should be described in item 16H—"Other."

Enter all charges—covered and noncovered—in the "Total Inpatient Charges" column. Charges for noncovered services and items, except for the services of facility-based physicians, should be itemized in the "Noncovered Charges" column. Charges for all noncovered days which fall within the period described in item 20 (on a bill covering both covered and noncovered days, or noncovered days only) should also be shown in the "Noncovered Charges" column. If it is necessary to explain an item, a statement may be attached. Any statement attached should show the patient's name and claim number. Only one copy is needed. (Details concerning coverage are contained in Chapter II. See § 405 on submitting bills for noncovered days.)

If the facility and the intermediary agree, the facility may use machine-produced ledger sheets to report services and charges. The ledger sheets submitted should show total charges for each department. Hotel-type billings which summarize by day but not by department are not acceptable.

Where ledger sheets are submitted in lieu of item 16, each ledger sheet attached should show the patient's name and claim number.

Unless the days, rate, and type of accommodation are clearly shown on the machine bill, the accommodation entries on the form SSA-1478 should be completed. The facility should complete item 12 on the billing form, where applicable. The facility should also complete items 17, 18, and 19, unless the coinsurance, Part B services and charges, and Part B charges paid by the



patient are clearly shown on the attached machine bill.

**Item 16A. 1-Bed Accommodation.**—Where a patient needed a private room for medical reasons, explain the medical necessity in item 12. The medical necessity should be described by the doctor in the patient's medical record or other document retained by the facility. Enter the customary charge for a 1-bed accommodation in the "Rate" column and complete the "Total Inpatient Charges" column.

If the patient requested a 1-bed accommodation, payment cannot be made for more than the cost of semiprivate accommodations. The patient is responsible for the difference between the customary private room charges and the most prevalent semiprivate room charges at the time of admission. The charge for the 1-bed accommodation should be entered in the "Rate" column, and the product of this rate times the number of days should be shown in the "Total Inpatient Charges" column. Show the total charges to the patient in the "Noncovered Charges" column.

Check the "Patient's Request" block in item 12, and enter the most prevalent semiprivate rate in the space provided in item 12. (See § 303.2, Item 12, for computation of the most prevalent rate.)

If private accommodations were furnished and this was not medically necessary nor at the patient's request, the facility should check the "Other Reason" block and give a brief explanation in item 12. In this case the program will cover only the cost of semiprivate accommodations and no charge may be made to the patient. The facility should use line 16B and the semiprivate rate should be shown in the "Rate" column, even though private accommodations were actually furnished. The "Total Inpatient Charges" column should show the total charges for semiprivate accommodations. Since no additional charge can be made to the patient in this situation, no entry should be made in the "Noncovered Charges" column.

**Item 16B. 2-3-4-Bed Accommodation.**—If the patient occupied semiprivate accommodations, show the number of days, the semiprivate rate, and the total charges.

**Item 16C. 5-Or-More-Bed Accommodation.**—If the patient is in an accommodation of 5-or-more beds, show the number of days, the ward rate, and the total charges.

Item 12 must be completed to explain the reasons for this accommodation. If the patient did not request the ward accommodations, the amount representing the most prevalent customary charge for semiprivate accommodations at the time of admission should be shown

in the space provided in item 12. (See § 303.2, Item 12.)

If the ward accommodation was not requested by the patient nor provided for a reason consistent with the purposes of the health insurance program, the intermediary will subtract the total ward charges from the total semiprivate charges as determined by using the rate entered in item 12, and enter the difference in item 29, "Semi-Private Differential." Payment to the extended care facility must be reduced at the end-of-the-year settlement by the amount of such differentials. (See § 212.2C.)

**Items 16D Through H.** Enter all charges for supplies or services—covered or noncovered—in the "Total Inpatient Charges" column. Show charges for noncovered services and items in the "Noncovered Charges" column. When there is insufficient space to describe all services performed in item 16H (Other), a separate attachment for such services and charges may be used. Continuation sheets should **not** be used.

Where items and services, which are in excess of or more expensive than those covered by the program, are requested by the patient the difference between the amount customarily charged for the items or services requested, and the amount customarily charged for the items or services covered by the program, should be shown as noncovered charges.

**Item 16I. Totals.**—Enter the total inpatient charges and the total noncovered charges.

**Item 17. Coinsurance.**—Enter the \$5 daily coinsurance charge, if applicable, and the number of days covered by this bill which fall in the coinsurance period (which begins with the 21st inpatient extended care facility day in a spell of illness). Multiply the number of days by \$5 and show that amount in the money column.

**Item 18. Part B Services Furnished to Other than Inpatients.**—Enter Part B services, such as transportation furnished in an extended care facility ambulance, in this item. If facility-based physician charges are ordinarily included in total charges to the patient, these charges should be included in item 16. They should **not** appear in item 18.

**Item 19. Part B Charges Paid by Patient.**—Enter here any Part B deductible and/or coinsurance amount paid by the patient. (See § 115.3.) The facility should try to learn from the patient whether he had any previous Part B services which could count toward the Part B deductible before collecting that amount from the patient. If the deductible is met, the patient is responsible for the 20 percent coinsurance amount. The intermediary will refund directly to the patient any



Part B deductible overcollection made by the facility.

**Item 20. Statement Covers Period.**—Enter the beginning and ending dates of the period covered by this statement. The beginning date of this period should be no earlier than January 1, 1967, even though the admission date in item 9 may be earlier than that.

Where the patient is still in the facility, show the last day of the period being reported on the bill, whether or not this last day was a day of covered service. Otherwise, show the date of discharge or death. (See § 405 for information on completing the form after benefits have been exhausted.)

**Item 21. Leave Days.**—Enter the number of days on which the patient was not present in the extended care facility at midnight and for which the facility is not being reimbursed. Attach a brief explanation to the billing form.

It is not necessary to complete a notice of admission and billing form each time a leave of absence occurs.

**Item 22. Date UR Notice Received.**—Enter the date the extended care facility received the notice from the Utilization Review Committee (or the group responsible for the review of utilization) that further stay by the patient is not medically necessary.

**Item 23. Date Benefits Exhausted.**—Enter the date on which the patient's benefits were exhausted, if this occurred before the beneficiary's discharge or death and during the period described in item 20. Make no entry in this space when the Reply to the Notice of Admission showed **no** days remaining.

**Item 24. Total Days.**—Enter here the total days of covered extended care facility care for the period shown in item 20. Count the day of admission, but do not count the day of discharge. Do not count days for which payment cannot be made because benefits were exhausted, a workmen's compensation payment was made or expected (attach an explanation), or because a utilization review notice was received stating that extended care facility care was no longer necessary. (Payment may be made for 3 benefit days after the day such notice was received.) Do not count "leave of absence" days.

**Items 25 and 26. Discharge Information.**—If the patient is still in the extended care facility when the billing is submitted, check "Still Patient." Otherwise, check "Discharged" or "Died" in item 25. Show the date of discharge or death in item 26.

**Item 27. Computation of Interim Payment.**—Payments to the facility under the hospital insurance plan are based on the reasonable cost of service provided. The precise reasonable cost of services cannot be determined until the end of the year when final cost fig-

ures are known. However an interim settlement will be made on the basis of each bill. This interim settlement method will be worked out by the intermediary and the extended care facility. If the facility wishes to make a computation for its own records, it should do so on the Extended Care Facility copy of the form or on a separate sheet. It can estimate the cost of covered services by the approved method and subtract any applicable deductible and coinsurance to arrive at the reimbursement amount.

A separate computation should be made for any Part B services furnished.

**Items 28 Through 31.** For intermediary use.

**Item 32. Extended Care Facility Certification and Signature Line.**—An extended care facility representative should make sure that the required physician's certification and recertification are on file. The representative should then sign and date the form before it is submitted to the intermediary.

**Item 33. Approved By and Date.**—For intermediary use.

**402.1 Disposition of Copies of Completed Forms SSA-1478.**—Retain the copy marked "Extended Care Facility Copy." The following remaining copies should be submitted to the intermediary (or to the Bureau of Health Insurance, Direct Reimbursement Branch, Baltimore, Maryland, in a direct-dealing situation):

- a. The original copy, which will be maintained in the intermediary's (or SSA's) files.
- b. The copy marked "Social Security Copy."
- c. The copy marked "Carrier Copy," for the Part B intermediary to associate with any related physicians' bills.

#### **404. PROVIDER BILLING FOR PATIENT SERVICES BY PHYSICIAN (FOR SSA-1554)**

A. This form is used to bill for facility-based physicians' services to patients (see § 215) where:

1. The beneficiary assigns payment to the physician,
2. The physician agrees that the reasonable charge, as determined by the intermediary, will be the full charge for services rendered and,
3. The physician has authorized the extended care facility to accept the assignment and collect the payment on his behalf.

The form should be attached to the extended care facility bill for the stay or services to which the physicians' charges apply. It should be forwarded with the SSA-1478 to your regular intermediary for provider services. Your intermediary will forward it to



**PROVIDER BILLING FOR PATIENT SERVICES BY PHYSICIANS  
MEDICAL INSURANCE BENEFITS - SOCIAL SECURITY ACT**

Form Approved.  
Budget Bureau No. 72-R747

(Use this form only where the provider has billing arrangement to collect physician charges for individual patient care pursuant to agreement with the physician.)

1. PATIENT'S LAST NAME	FIRST NAME	MI	2. HEALTH INSURANCE CLAIM NUMBER
3. PATIENT'S ADDRESS (Street number, City, State, Zip Code)			4. DATE OF BIRTH
6. NAME AND ADDRESS OF PROVIDER			5. SEX <input type="checkbox"/> M <input type="checkbox"/> F
			7. PROVIDER NO(S).
			8. MEDICAL RECORD NO.

**9. ASSIGNMENT:** I assign payment for unpaid charges of the physician(s) listed on this form.

**AUTHORIZATION:** I authorize release of any information required to act on this claim and permit a photographic reproduction of this authorization be used in place of the original.

The above information is correct. I request payment on my behalf for the medical insurance benefit, if any, payable for the reasonable charges for services described. I understand I am responsible for any medical insurance deductible and 20% of the remaining reasonable charges.

SIGNATURE OF PATIENT (Or his representative)

SIGNATURE OF PATIENT (Or his representative)										DATE SIGNED	
10 A.	B.	C.	D.	E.	F.	G.	H.	LEAVE			
DATE OF EACH SERVICE	NAME OF PHYSICIAN	PLACE OF SERVICE I, H, O, E, C, F, M	FULLY DESCRIBE SURGICAL OR MEDICAL PROCEDURES	DEPARTMENT	TOTAL CHARGE WHEN APPLICABLE	PERCENTAGE OF TOTAL CHARGE	CHARGE FOR PHYSICIANS SERVICES	BLANK			
11. DIAGNOSES AND CONCURRENT CONDITIONS										12. EMPLOYMENT RELATED	
										<input type="checkbox"/> YES <input type="checkbox"/> NO <i>(If yes, give name and address of employer)</i>	
										TOTALS \$	
										Deductible and coinsurance paid	
										Any unpaid balance	

3. PROVIDER CERTIFICATION: The physicians named in item 10B have authorized the provider to accept assignment and receive payments in their behalf (and such authorizations are on file and still in effect.)

SIGNATURE OF PROVIDER REPRESENTATIVE



the carrier for physicians' services with his copy of the regular billing form.

Do not use Form SSA-1554 to report the services of a physician who wishes the medical insurance payment to be made directly to himself. Inform that physician that he and the patient may complete a medical insurance benefits claims form (Request for Payment, Form SSA-1490) for that purpose. A patient who has been billed directly by a physician may also use this form to claim medical insurance payments from the carrier.

B. The following is a sample of an authorization for use by providers in connection with provider billing for facility-based physicians' services. *A one-time execution of this authorization is all that is necessary by each physician.* The authorization should be retained in the provider's files.

"I hereby authorize the (name of institution) or any of its duly authorized administrators to accept on my behalf any assignment made by any individual who receives medical treatment from me at the (name of institution) of the amount payable to such individual under Part B of Title XVIII of the Social Security Act and to receive on my behalf any payments which may be made pursuant to such assignment. It is understood and agreed that the reasonable charge which will serve as the basis for payment in accordance with the terms of such assignment shall be the full charge for the services."

An additional statement should also include the individual arrangements agreed upon by the provider and the physician governing the conditions of withdrawing the authorization.

#### **404.1 Completing Items on Form SSA-1554.—**

**Item 1. Patient Identification.**—The patient's name should be the same as that shown on his health insurance card with the last name first.

**Item 2. Health Insurance Claim Number.**—Enter the health insurance claim number shown on the patient's health insurance card or related extended care facility billing form.

**Item 3. Patient's Address.**—Show the address of the person who is assigning benefits, whether this is the patient or someone acting on his behalf.

**Items 4 and 5. Date of Birth and Sex.**—Complete the "Date of Birth" and "Sex" blocks. If the date of birth is unknown, the facility should transmit the bill without the date of birth. If only the year of birth is known, but not the month or day, show the year. While the date of birth is useful as identification and should

be shown when available, a billing may be processed without the date of birth.

**Items 6 and 7. Provider Identification.**—Enter the name and address of the facility and the assigned health insurance provider number. These entries may be stamped or preprinted.

**Item 8. Medical Record Number.**—Show the patient's medical record number if one is assigned by the provider.

**Item 9. Authorization and Signature.**—Have the patient or his authorized representative read the statement on the form or the statement in the facility admission record if the facility uses the alternate signature procedure (see § 250.2). If the facility obtains the signature on its own form, the signature line of Form SSA-1554 should be stamped to indicate that the "Patient's request for payment is on file."

If the patient cannot sign his name because of his physical or mental condition, another person may sign on his behalf; e.g., John J. Jones by Jack A. Smith. In certain situations, an extended care facility representative may sign on behalf of the patient. (See § 251 for who may file a payment request.)

Briefly explain the reason why the patient did not sign the form himself and show the relationship of the signer to the patient. This explanation should be retained in the facility's file if the signature is obtained on the facility's own record. If the signature is on Form SSA-1554, the explanation should accompany or be included on the billing form.

The statement should be read to the patient who signs by mark. The signature by mark should be witnessed by a person who knows the patient. Enter the name and address of any person witnessing the signature by mark.

**Item 10A. Date of Service.**—Show the date for each service when the "item-by-item" method is used to bill for physician charges. Inclusive dates may be shown only where the provider and physician arrange to use the "optional" method to bill such charges (see § 404.3).

**Item 10B. Name of Physician.**—Show the name of the physician for whom the facility is billing for services. Upon arrangement with the intermediary, billing may be in the name of the facility department head. This item should be omitted when billing for services by the "optional" method (see § 404.3).

**Item 10C. Place of Service.**—Enter code: "ECF."

**Item 10D. Surgical or Medical Procedures.**—Except where the "optional" method is used in determining physicians' charges, give the medical laboratory, and



X-ray procedures performed for each date during the billing period. The procedures should be clearly identified by the use of standard nomenclature.

Where the "optional" method is used, services are identified on a departmental basis in item 10E and this space is left blank. (See § 404.3.)

**Item 10E. Department.**—Enter the name of the department associated with the physician's services; e.g., X-ray, or laboratory.

**Items 10F and 10G. Total Charge and Percentage of Total Charge.**—If the provider and the physician agree to bill for physician charges using the "optional" method, enter in item 10F the provider's total charges where the charges are combined charges for extended care facility and physician services shown in item 10E. Show in item 10G the approved percentage of the total departmental charge entered in item 10F. Items 10F and 10G are used only where the "optional" method has been agreed upon by the extended care facility and physician and approved by the intermediaries (see § 404.3).

Details as to distinguishing the physician charge from costs which are reimbursable to the extended care facility under the hospital plan are contained in the provider reimbursement principles.

**Item 10H. Charge for Physicians' Services.**—Enter the money amount attributable to physicians' services. Total all physicians' charges and enter the amount in the "Totals" block. Show any part of the \$50 deductible and coinsurance paid by the patient and subtract the amount paid from the total charges.

**Item 11. Diagnosis and Concurrent Conditions.**—Show the most significant of the conditions first in entering diagnoses. Use recognized nomenclature such as that contained in "*Current Medical Terminology, Standard Nomenclature of Diseases and Operations*," and the American Psychiatric Association's "*Diagnostic and Statistical Manual*," etc. Show any concurrent conditions associated with the primary diagnosis.

**Item 12. Employment Related.**—Indicate whether the condition is employment related. If the condition is or may be employment related, give the name and address of the employer, if known. Payment may be made subject to reimbursement if a workmen's compensation claim is pending and no settlement is foreseeable. (See §§ 258ff.)

**Item 13. Provider Certification Signature, and Date.**—The signature of the facility representative serves as a request for payment on behalf of physicians. The signature is also a certification that proper authorizations are on file and are still in effect.

**404.2 Disposition of Form SSA-1554.**—Since

this form has only a single copy, the facility may wish to make a carbon copy when preparing the form, for its own files. The original should be attached to the extended care facility bill and forwarded to the intermediary for provider services. Where no extended care facility bill is being submitted, send the form direct to the intermediary for physicians' services.

#### **404.3 Description of "Item-by-Item" and "Optional" Methods for Physicians' Components.**—

When the "item-by-item" method is used, the facility and physicians determine a schedule of separate identifiable charges for each procedure. This schedule is filed with the Part A and Part B intermediaries after agreement is reached with them regarding the appropriateness of all charges. (See § 215.)

A detailed reporting of the surgical or medical procedures is required to enable intermediaries to approve and make payment for physician services under supplementary medical insurance (Part B) in accordance with the schedule of charges established by the provider and physician. Under this method of determining the physician's charge, an itemization of services is necessary.

Under the optional method, the charges for services of a provider-based physician are determined by applying a single uniform percentage of the combined charge for facility and physician services. The percentage established by the facility and the physician must be approved by and filed with the intermediaries and will be used in determining the charge for physician services.

Where the optional method is followed, it will not be necessary for providers to identify the surgical or medical procedure in item 10D of the Provider Billing for Patient Services by Physicians. It will be sufficient to indicate the department by name, i.e., laboratory, radiology, etc., in item 10E. The total combined departmental charge for each department and the applicable single uniform percentage must be entered in columns 10F and 10G.

#### **405. SUBMITTING BILLING FORMS IN NO-PAYMENT CASES**

The SSA maintains a record of inpatient hospital and extended care facility benefits paid for each beneficiary. To determine whether a new spell of illness has begun after such payment has been made, the Social Security Administration must know whether there has been a period of 60 consecutive days, following the last day of covered extended care facility or hospital inpatient services, during which the beneficiary was not an inpatient of any hospital or extended care facility, participating or nonparticipating. For this reason once

a spell of illness has begun, all subsequent hospital and extended care facility stays must be reported to the Social Security Administration, regardless of whether hospital insurance benefits are payable for such stays.

Information obtained by the extended care facility from the patient and entered in item 11 of the form SSA-1478 will alert the intermediary to prior stays in both participating and nonparticipating institutions and the need for updating the patient's utilization record. In addition to this, however, all participating extended care facilities should submit billing forms reporting extended care facility stays by beneficiaries, even though no payment can be made to the extended care facility, to help assure that accurate and current beneficiary utilization records are maintained.

Specifically, the extended care facility should submit a billing form:

- for the period from the date benefits were exhausted until the patient's discharge or death;
- for an inpatient extended care facility stay for which payment is made or can be expected by a workmen's compensation plan;
- for an inpatient extended care facility stay when the 3-day prior hospital stay or 14-day transfer requirements were not met, or when the services were not covered for some other reason;
- for the period beginning with the fourth day after a utilization review notice (concerning the lack of medical need for further extended care facility

services) is received, and ending with the date of discharge or death.

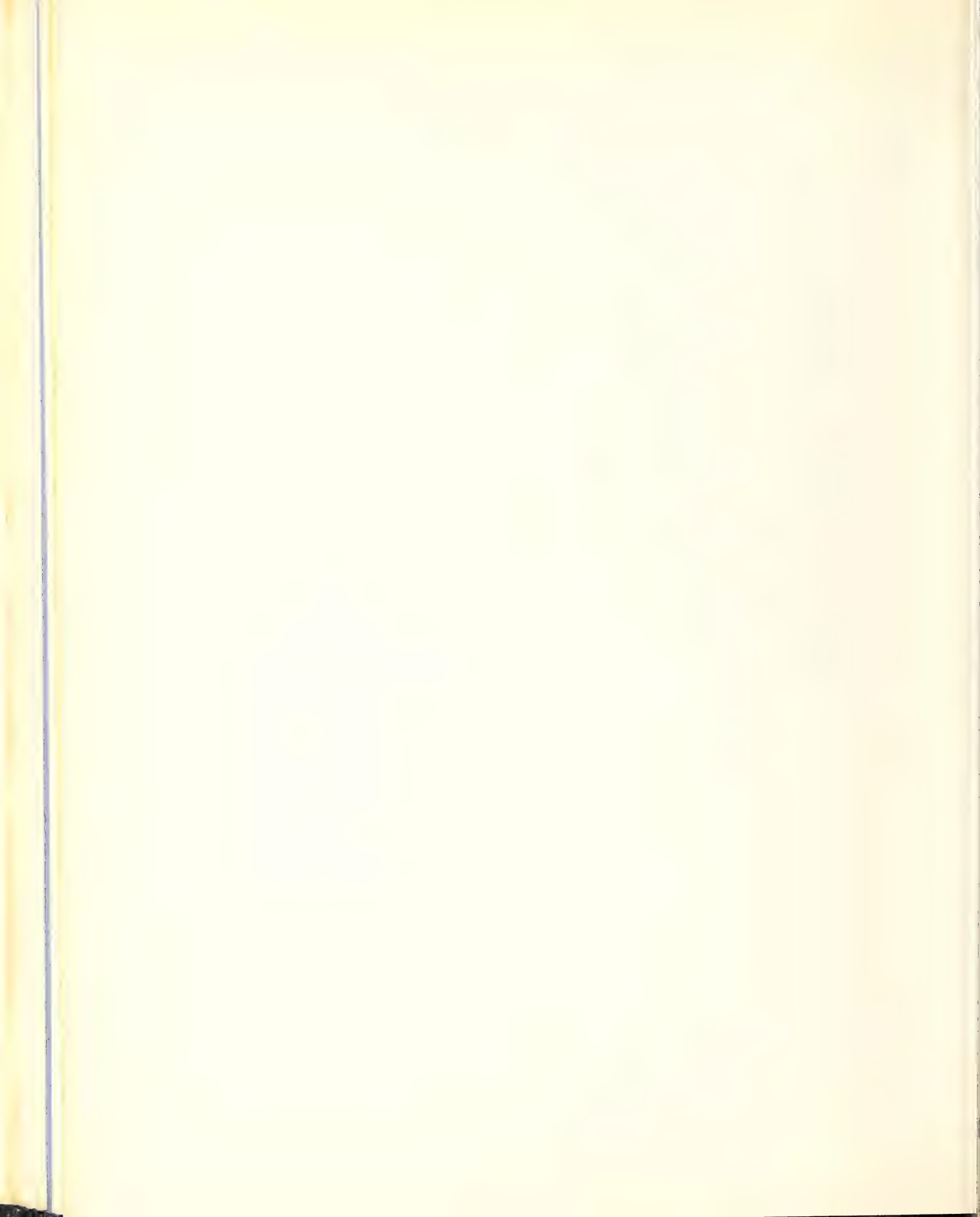
- where the patient has refused to sign a request that payment be made on his behalf. (See § 306.)

When an extended care facility submits a billing form in one of these cases where no payment can be made, only the following items on the billing form should be completed: Items 1 through 3, 5 through 7, 9 through 11, 14, 15, 16I, 18, 20, 25, and 32.

Billing forms should be submitted in no-payment cases every 60 days until the patient's discharge or death. However, where both noncovered and covered days are reported on the bill, all the items must be completed. When noncovered days are included in the period covered by the bill, the extended care facility should include a brief explanation (except in a "benefits exhausted" case) on an attachment to the billing form.

#### **406. PROCEDURES FOR SUBMITTING CORRECTED BILLS**

The extended care facility may discover that a bill already submitted is incorrect. To correct a previously submitted bill, the extended care facility should reproduce a copy of it and make the necessary corrections in the appropriate items. The corrected copy should be marked "Debit-Adjust" in the upper right margin, and the copy should be sent to the intermediary. A corrected bill need not be submitted where total inpatient charges are not changed by more than \$10 or the interim cost reimbursement by more than \$1.





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# EXTENDED CARE FACILITY MANUAL REVISION

U.S. DEPARTMENT OF  
HEALTH, EDUCATION, AND WELFARE  
SOCIAL SECURITY ADMINISTRATION

HIM-12

HEALTH INSURANCE FOR THE AGED

JANUARY 1967

NO.1

## New Material

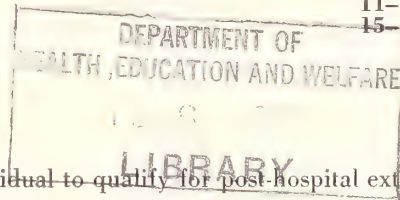
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This revision makes the following changes.

**Sec. 211.4.**—Under the law, it is possible for an individual to qualify for post-hospital extended care services on the basis of a 3-day hospital stay which ends as early as July 1, 1966, provided he is admitted to an extended care facility within 14 days after discharge from the hospital. However, the fact that institutions could not begin participating in the program as extended care facilities until January 1, 1967, has given rise to a question as to the identity of institutions which can be considered extended care facilities for purposes of the 14-day requirement prior to January 1, 1967. This is a new section which explains the requirements which an institution must meet to be deemed an extended care facility as of July 1, 1966, for purposes of satisfying the 14-day transfer requirement.

**Sec. 303.2.**—*Item 5* has been clarified to indicate that the entry relates to the most recent discharge from a hospital after a stay of at least 3 days. Also, if the facility is unable to complete the item, an explanation should be attached to the admission notice sent to the intermediary.

In *Item 11* the 60-day period for showing prior hospital or extended care facility stays should be measured from the date of admission to the hospital shown in *Item 5*, rather than from the date of current extended care facility admission, as previously indicated.

Arthur E. Hess

Director, Bureau of Health Insurance

Changed material is indicated in the margin of a page in the following manner:

☐ ☐ = Line on which change begins  
or  
☐ ☐ = Line on which change ends

Revision transmittal sheets should be filed at the end of the manual as a record of receipt.





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Social Security Administration as a provider of services, and has entered into an agreement with the Administration which provides that it will not charge any patient or other person for covered items and services, for which an individual is entitled to have payment made under the program; will return any money incorrectly collected; and will provide services on a non-discriminatory basis in compliance with Title VI of the Civil Rights Act of 1964.

## **206. UNDER ARRANGEMENTS**

A provider may make arrangements with others to furnish covered items or services. When such arrangements are made, receipt of payment by the provider for the services (whether it bills in its own right or on behalf of those furnishing the services) must relieve the beneficiary or any other person of further liability to pay for the services.

### **Coverage of Services Under Hospital Insurance**

## **210. REQUIREMENTS—GENERAL**

Effective January 1, 1967, posthospital extended care services furnished to inpatients of an extended care facility are covered under the hospital insurance program. Patients having hospital insurance coverage are entitled to have payment made on their behalf for the reasonable cost of covered extended care services furnished by the facility, by others under arrangements with the facility, or by a hospital with which the facility has a transfer agreement in effect.

## **211. PRIOR HOSPITALIZATION AND TRANSFER REQUIREMENTS**

In order to have payment made for posthospital extended care services, the individual must have been an inpatient of a hospital for at least 3 consecutive calendar days and have been transferred to an extended care facility within 14 days after discharge from the hospital.

**211.1 Three-Day Prior Hospitalization.**—The hospital discharge must occur after June 30, 1966, or on or after the first day of the month in which the individual attains age 65, whichever is later. In de-

termining whether the required 3-day period of hospitalization has been met, the day of admission, **but not the day of discharge**, is counted as a hospital inpatient day.

The hospital need not be one with which the extended care facility has a transfer agreement; but must at least be one which meets all of the requirements in the definition of hospital, except the utilization review and health and safety requirements.

To be covered, the extended care services must have been necessitated by a condition which occasioned the patient's qualifying hospital stay, or by a condition which arose while in the facility for treatment of a condition for which he was previously hospitalized.

**211.2 Fourteen-Day Transfer.**—In determining the 14-day period, the day of discharge from the hospital is not counted in the 14 days. For example, a patient discharged from a hospital on August 1, and admitted to an extended care facility on August 15 was admitted within 14 days.

If the individual leaves the extended care facility and is readmitted to the same, or any other qualified extended care facility (see § 201) within 14 days, he is deemed not to have been discharged from an extended care facility for purposes of this requirement. Thus, the period of extended care services may be interrupted briefly and then resumed, if necessary, without hospitalization preceding the readmission to a qualified facility.

Hospitalization within the 14-day period after discharge from an extended care facility may also be treated as a return to an extended care facility within the 14-day period. For example, a person suffers a relapse which requires a resumption of skilled nursing care within 14 days after he is discharged from an extended care facility. Because there is no bed available in an extended care facility, he is placed in a hospital for less than 3 days and is then placed in a qualified extended care facility. Under these conditions, the person would be considered as having returned to an extended care facility within the 14-day period, even if the second admission to the extended care facility occurs more than 14 days after his first discharge from such a facility.

**211.3 Requirements Applicable to Extended Care Facility Inpatients on January 1, 1967.**—A hospital insurance beneficiary who is an inpatient of an extended care facility prior to January 1, 1967, the *effective* date of extended care coverage, is entitled to have payment made for extended care services beginning January 1, 1967, providing (1) he is on that date an inpatient of an institution which becomes a participating provider as of that date (see § 211.4 below for provisions applicable when the effective date of the facility's agreement is subsequent to January 1, 1967), and (2) he was transferred to that facility within 14 days of his discharge from a hospital of which he was an inpatient for 3 consecutive calendar days, and (3) he was discharged from the hospital after June 30, 1966, or on or after the first day of the month in which he became age 65, whichever is later, and (4) he has not been out of a facility for more than a 14-day period (§ 211.2 above).

**211.4 Institutions Deemed Extended Care Facilities as of July 1, 1966, for Purposes of the 14-Day Requirement.**—For purposes of the 14-day requirement, an institution will be deemed to be an extended care facility as of July 1, 1966, if the effective date of its agreement is January 1, 1967. An institution having an agreement which has an effective date later than January 1, 1967, but prior to February 1, 1967, will also be deemed an extended care facility as of July 1, 1966, providing its application for participation in the program was filed prior to December 17, 1966. An institution which filed an application for participation in the program before December 17, 1966, but subsequently withdrew its application will also be deemed to be an extended care facility as of July 1, 1966, but only if it filed a request for reinstatement of its application for participation before January 1, 1967, and has an agreement with an effective date prior to February 1, 1967. An institution which filed for participation after December 16, and has an agreement that is effective later than January 1, 1967, cannot be deemed to be an extended care facility as of July 1, 1966. It would be considered an extended care facility only as of the date of its agreement. The date of filing an application for participation in the program for this purpose is the date on which it is received in the State agency.

The following examples illustrate the application of the 14-day requirement as it applies to the above institutions:

**Example 1:** John, following a qualifying hospital stay ending on August 15, 1966, is admitted within 14 days to an institution which is deemed to be an extended care facility as of July 1, 1966. He remains an inpatient of that institution until March 31, 1967, when he is discharged. The effective date of the institution's agreement is January 15, 1967. John would be entitled to posthospital extended care benefits starting January 15.

**Example 2:** David, following a qualifying hospital stay ending on August 15, 1966, is admitted on August 19, 1966, to an institution which is *not* deemed to be an extended care facility as of July 1, 1966. He remains an inpatient of this institution until September 30, 1966, when he is discharged. On October 2 he is admitted to an institution which is deemed to be an extended care facility as of July 1, 1966, and is still an inpatient of the institution on January 15, 1967, the effective date of the institution's agreement. David is not eligible for extended care benefits since he did not, within 14 days of his qualifying hospital stay, enter an institution deemed to be an extended care facility as of July 1, 1966. If the first institution had been one which is also deemed to have been an extended care facility as of July 1, 1966, David would be entitled to benefits as of the effective date of the second institution's agreement.

**Example 3:** On September 30, 1966, within 14 days of a qualifying hospital stay, Sue entered an institution which is deemed to be an extended care facility as of July 1, 1966, its agreement being effective January 30, 1967. She is discharged from the institution on January 25, 1967. On February 7, 1967, she is admitted to another extended care facility having an agreement effective February 4, 1967. Since Sue is not considered to have been discharged from the extended care facility (§ 211.2), she would be entitled to benefits beginning February 7, 1967.

**Example 4:** Institution A's participation agreement is effective February 10, 1967. Doug, who was discharged from a qualifying hospital stay on January 25, is admitted to Institution A on February 1, 1967. Since Institution A does not meet the requirements for being deemed an extended care facility as of July 1, 1966, the earliest date it can be considered an extended care facility is February 10, 1967, the effective date of its agreement. Therefore, although Doug entered Institution A within 14 days of a qualifying hospital stay, he is not entitled to benefits since the institution was not an "extended care facility" until after the 14-day period involved had expired.



## 212. COVERED EXTENDED CARE SERVICES

Patients covered under hospital insurance are entitled to have payment made on their behalf on a reasonable cost basis for covered extended care services. If a patient receives items or services in excess of, or more expensive than those for which payment can be made, payment will be made only for the reasonable cost of the covered items or services. If the items or services were requested by the patient, the facility may charge him the difference between the amount customarily charged for the services requested and the amount customarily charged for covered services.

An **inpatient** is a person who has been admitted to an extended care facility for bed occupancy for purposes of receiving inpatient services. A person is considered an inpatient if formally admitted as an inpatient with the expectation that he will remain at least over night and occupy a bed even though it later develops that he can be discharged and does not actually use a bed over night.

**Note: Custodial care (see § 240.9) is not covered extended care service.**

The following extended care services are covered under hospital insurance:

### 212.1 Nursing Care Provided by or Under the Supervision of a Registered Professional Nurse.—

**Note: The services of a private-duty nurse or other private-duty attendant are not covered.**

Private-duty nurses or private-duty attendants are registered professional nurses, licensed practical nurses, or any other trained attendant whose services are restricted to a particular patient by arrangement between the patient and the private-duty nurse or attendant.

**212.2 Bed and Board in Semiprivate Accommodations.**—Hospital insurance will pay for the reasonable cost of semiprivate accommodations (two, three, or four-bed accommodations) in connection with nursing care. When accommodations other than semiprivate are furnished, the following rules will govern.

**A. Private Rooms Medically Necessary.**—Payment may be made for the reasonable cost of a private room or other accommodations more expensive than semiprivate only when such accommodations are medically necessary. Private rooms will be considered medically necessary when the patient's condition requires him to be isolated for his own health or that of others.

The term isolation may apply when treating a number of physical and mental conditions. These include communicable diseases which require isolation of the

patient for certain periods. Privacy may also be necessary for patients whose symptoms or treatment are likely to alarm or disturb others in the same room.

**B. Private Rooms Not Medically Necessary.**—When accommodations more expensive than semiprivate are furnished the patient because, at the time of admission, less expensive accommodations are not available, the program may pay only the reasonable cost of semiprivate accommodations.

When accommodations more expensive than semiprivate are furnished the patient **at his request** in the absence of medical necessity, the facility may charge the patient no more than the difference between the customary charges for the accommodations furnished and the customary charges for semiprivate accommodations at the most prevalent rate at the time of admission. No such charge may be made to the patient unless he requested the more expensive accommodations. (See D. below for a definition of "customary charges" and "most prevalent rate.")

**C. Wards.**—When accommodations less expensive than semiprivate are furnished **at the patient's request or for a reason determined to be consistent with the purposes of the health insurance program**, payment may be made for the reasonable cost of the accommodations furnished. It is considered to be consistent with the program's purposes to furnish bed and board in less expensive accommodations where semiprivate accommodations are not available. However, the patient must be moved to semiprivate accommodations when they become available. (Payment to extended care facilities which have **only** ward accommodations will be made on the basis of the reasonable cost of the accommodations furnished.)

In some cases, a patient may be placed in accommodations less expensive than semiprivate **neither at his request nor for a reason consistent with the program's purposes**. It is not consistent with the purposes of the law to assign a patient ward accommodations on the basis of his social or economic status, his national origin, race, or religion, or his entitlement to benefits as a medicare patient, or any other discriminatory reason, when the patient has not requested such assignment. An extended care facility which repeatedly assigns patients to accommodations less expensive than semiprivate **neither at the patient's request nor for reasons consistent with the purposes of the program** will be subject to termination of its participation agreement.

When ward accommodations are furnished **neither at the patient's request nor for a reason consistent with**





### 303. ADMISSION NOTICE

A participating hospital can receive payments for a specified number of days under the hospital insurance program for inpatient services furnished a beneficiary in good faith during the period preceding receipt of the intermediary's report of eligibility, even though that report shows that as of the time of its receipt by the hospital the beneficiary's entitlement to inpatient hospital services has been exhausted for the current spell of illness. **HOWEVER, THERE IS NO SUCH GUARANTEE OF PAYMENT PROVISION IN THE LAW FOR EXTENDED CARE FACILITIES.** It is important that the extended care facility admission notice be sent as soon as possible, so that a speedy report on the patient's eligibility may be given to the facility.

The admission notice (see Exhibit 3) data sent to the intermediary should include the information called for in items 1 through 14 of the form SSA-1478; except that where item 12 applies, its completion may be delayed until the bill is submitted. The bottom two copies of the form SSA-1478 are the admission notice copies. Depending on the arrangements made with the intermediary or the social security district office, the facility may send the admission notice copies of the billing form by mail or messenger, or may submit the information from these forms by wire or telephone.

**303.1 Completing Admission Notices.**—The hospital transfer form should show the patient's name and address; health insurance claim number; dates of hospital stay; welfare agency name, address, and case number, if applicable; and a notation indicating workmen's compensation, if any. The facility should rely on this information in completing items 1, 2, 3, 5, 10, 11, and 14 of the form SSA-1478. (Additional information from the patient or hospital may be required to complete items 10 and 11.)

All entries on the form should be typed. Show month, day, and year entries in 6-digit numbers, e.g., 07/09/67.

#### 303.2 Explanation of Admission Notice Entries

**Item 1. Patient's Name.**—The patient's name should be the same as that shown on the hospital transfer form or on his health insurance card, with the last name first.

**Item 2. Health Insurance Claim Number.**—Enter the health insurance claim number as shown on the hospital transfer form, the patient's health insurance card, utilization notices, the temporary eligibility notice, or as reported by the social security district office.

**Item 3. Patient's Address.**—Enter the patient's mailing address.

**Item 4. Attending Physician.**—Enter the name of the physician who is expected to certify the medical necessity of the extended care facility stay.

**Item 5. Dates of Prior Hospital Stay.**—Enter the dates of stay in the hospital from which the patient was most recently discharged after a stay of at least 3 days. If the facility does not have in its files a hospital transfer form showing these dates, or a written report of a telephone conversation with the hospital in which these dates were furnished, then the facility should not complete item 5. If item 5 is not completed attach an explanation to the admission notice. The transferring hospital's name and address should be shown in item 11, and the intermediary will verify the prior-stay dates and enter them on the billing form.

**Items 6 and 7. Provider Identification and Provider Number.**—Enter the name and address of the extended care facility and the assigned health insurance provider number. This information may be pre-printed or stamped on all copies of the form, if desired.

**Item 8. Medical Record Number.**—Enter the number, if any, used by the facility to identify the patient's medical record.

**Item 9. Date of Admission.**—Enter the date of the current admission in 6-digit numbers; e.g., 09/07/67. Show the actual date of admission even though this was before January 1, 1967.

**Item 10. Payment Source.**—Indicate who will pay for any services to the patient which will not be paid for by the health insurance program. More than one source may be checked, if applicable. If State public welfare agency payments will be made, show the name and address of the agency and the patient's case number, if known.

**Item 11. Names and Addresses of Prior-Stay Institutions.**—Enter **first** the name and address of the hospital from which the patient was most recently discharged, after a stay of at least 3 days. The first entry in item 11 should always be the name and address of the hospital to which item 5 refers.

Next enter the name and address of any extended care facility the patient entered in the period between his discharge from the hospital item 5 refers to, and his current facility admission. Also, enter the name and address of any hospital the patient may have entered in this period for a stay of less than 3 days.

The last entries in item 11 should be the names and addresses of any hospital or extended care facility (not already listed) from which the patient was discharged

in the 60-day period before the date of admission to the prior-stay hospital in item 5. This information is needed by the intermediary to determine the number of inpatient extended care facility benefit days for which the patient is eligible in the current spell of illness.

Prior-stay institutions should be listed in this item regardless of whether they are participating in the health insurance program.

**Item 12. If the Patient Received Accommodations Other Than Semi-private, Explain the Reason Why.**—This item needs to be completed only if the patient is being assigned to accommodations other than semi-private. If item 12 is not completed at the time of admission, and other than semi-private accommodations are furnished at a later date, item 12 should be completed when the bill is submitted.

If the patient is furnished private accommodations, check the appropriate block indicating the reason for this (patient's request, medical necessity, other reason). If the "medical necessity" or "other reason" block is checked, type a brief explanation in this item.

If private accommodations were medically necessary, the program will pay the reasonable cost of these accommodations. If a private room was furnished at the patient's request, the program will cover only the cost of a semi-private room, and the patient is responsible for the difference between the customary private room charges, and the most prevalent customary semi-private room charges at the time of admission. If the patient was furnished a private room and this was not at his request nor medically necessary, the program will pay only the cost of the most prevalent semi-private accommodations at that time; **and** the patient may not be charged any additional amount. (See § 212.2.A and B.)

If the patient requested a private room, show the most prevalent charge for semi-private accommodations in item 12.

If the patient is furnished ward accommodations, check the appropriate block indicating whether this was done at the patient's request or for another reason. If the "other reason" block is checked, type a brief explanation in this item. Then enter, in the space provided, the amount representing the most prevalent charge for semi-private accommodations in the facility at the time of admission. If the patient is assigned to a ward, and this was not at his request nor for a reason which the intermediary determines is consistent with program purposes, reimbursement to the facility will be based on the cost of semi-private accommodations minus the difference between the customary semi-private charges at the most prevalent rate and customary ward charges. (See § 212.C.)

To determine the most prevalent charge for semi-private accommodations:

- (1) Type of accommodation.
- (2) Total rooms of each type for each different room rate.
- (3) Total beds found in each type for each room rate.
- (4) Rate you charge daily for the type of room.
- (5) Your most prevalent charge for semi-private accommodations is that single rate that you charge for the largest entry appearing under your "total beds" column.

**Example:**

(1) Type of accommodation	(2) Total rooms of this type	(3) Total beds col. (1) x col. (2)	(4) Rate per day
2 beds .....	10	<b>20</b>	<b>\$14.00</b>
2 beds .....	8	16	15.00
3 beds .....	2	6	12.00
4 beds .....	1	4	9.00

*Note:* \$14.00 is the most prevalent semi-private charge.

**Item 13. Patient's Certification and Payment Request.**—Have the patient or his authorized representative read the statement on the form or the statement in the facility's admission record if the facility uses the alternate signature procedure (see § 250.2). If the facility obtains the signature on its own form, the signature line of the original of form SSA-1478 should be stamped to indicate that the "Patient's request for payment is on file." If the signature is obtained on form SSA-1478, it is sufficient if it is legible on the original only.

If the patient cannot sign his name because of his physical or mental condition, another person may sign on his behalf; e.g., John J. Jones by Jack A. Smith. In certain situations, a facility representative may sign on behalf of the patient. (See § 251 for who may file a payment request.)

Briefly explain the reason why the patient did not sign the form himself and show the relationship of the signer to the patient. This explanation should be retained in the facility's file if the signature is obtained on the facility's own record. If the signature is on form SSA-1478, the explanation should accompany or be included on the billing form.

The statement should be read to the patient who signs by mark. The signature by mark should be witnessed by a person who knows the patient. Enter the name



0000 - Definitions

Amounts

0000 - Requirements for Payments



Order HD 710244 A3

no. 12 - 2



# EXTENDED CARE FACILITY MANUAL REVISION

HEALTH INSURANCE FOR THE AGED

U.S. DEPARTMENT OF  
HEALTH, EDUCATION, AND WELFARE  
SOCIAL SECURITY ADMINISTRATION  
HIM-12

MARCH 1967

MAR 20 1967

NO. 2

LIBRARY

## New Material

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Sec. 405 (Cont.) — 406

## Replacement Pages

47-48  
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## Discard Pages

47-48  
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This revision makes the following changes:

**Section 405, Submitting Billing Forms in No-Payment Cases.**—The requirement of a billing every 60 days until the patient's discharge or death in no-payment cases has been eliminated. The billing will be submitted only at discharge or death. The number of items on form SSA-1478 which must be completed has been reduced. The reason for no payment is to be shown in Item 27.

**Section 405.1, Submitting Bills in No-Payment Cases Where Utilization Is Chargeable.**—This new section provides instructions for submitting billing forms where the patient refuses to request payment (or the physician refuses to sign a certification). In these cases, the extended care facility stays must be counted against the patient's 100 benefit days although no program payment will be made.

**Section 406, Procedure For Submitting Corrected Bills.**—The tolerance for submitting corrected bills does not apply where the number of inpatient days, or any Part B charge is affected. The method of preparing corrected bills has been clarified.

Arthur E. Hess

Director, Bureau of Health Insurance

Changed material is indicated in the margin of page in the following manner:

☐ = Line on which change begins  
 or  
☐ = Line on which change ends

Revision transmittal sheets should be filed at the end of the manual as a record of receipt.

U.S. Department of Health, Education and Welfare





## Chapter IV

### BILLING PROCEDURES

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List of Authorized Signatories .....	401	49
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Disposition of Copies of Completed Forms SSA-1478 .....	402.1	51
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EXTENDED CARE ADMISSION AND BILLING  
HOSPITAL INSURANCE BENEFITS - SOCIAL SECURITY ACTForm Approved  
Budget Bureau No. 72-R765

1. PATIENT'S LAST NAME		FIRST NAME		MI	2. HEALTH INSURANCE CLAIM NUMBER	
3. PATIENT'S ADDRESS (Street number, City, State, Zip Code)					4. NAME OF ATTENDING PHYSICIAN	
5. DATES OF PRIOR HOSPITAL STAY ADMISSION      DISCHARGE		6. EXTENDED CARE FACILITY NAME AND ADDRESS			7. PROVIDER NUMBER	
					8. MEDICAL RECORD NO.	
9. DATE OF THIS ADMISSION		10. PAYMENT SOURCE FOR CHARGES TO PATIENT				
		<input type="checkbox"/> SELF OR FAMILY <input type="checkbox"/> BLUE CROSS BLUE SHIELD <input type="checkbox"/> PUBLIC AGENCY (Give name) <input type="checkbox"/> PRIVATE INSURANCE <input type="checkbox"/> EMPLOYER OR UNION <input type="checkbox"/> OTHER (Explain)				
11. NAMES AND ADDRESSES OF ALL HOSPITALS AND EXTENDED CARE FACILITIES FROM WHICH PATIENT WAS DISCHARGED IN PAST 60 DAYS. (If this ECF, give dates of stay).						
12. REASON FOR OTHER THAN SEMI-PRIVATE ACCOMMODATIONS: <input type="checkbox"/> PATIENT'S REQUEST <input type="checkbox"/> MEDICAL NECESSITY (Describe) <input type="checkbox"/> OTHER REASON (Specify)						
Most Prevalent Semi-Private Rate \$						
13. PATIENT'S CERTIFICATION, AUTHORIZATION TO RELEASE INFORMATION, AND PAYMENT REQUEST. I certify that the information given by me in applying for payment under Title XVIII of the Social Security Act is correct. I authorize release of all records required to act on this request. I request that payment of authorized benefits be made on my behalf.						
SIGNATURE (Patient or authorized representative) (Signature by mark must be witnessed)					DATE	
14. ADMITTING DIAGNOSES (a) Primary  (b) Secondary					DO NOT USE THIS SPACE	
15. DISCHARGE OR CURRENT DIAGNOSES (a) Primary  (b) Secondary						
16. STATEMENT OF SERVICES RENDERED			TOTAL INPATIENT CHARGES	NON-COVERED CHARGES	20. STATEMENT COVERS PERIOD FROM      THRU	
ACCOMMODATIONS	DAYS	RATE				
A. 1-Bed					22. DATE UR NOTICE RECEIVED	23. DATE BENEFITS EXHAUSTED
B. 2-3-4 Bed						
C. 5 or more beds						
D. Physical Therapy					25. <input type="checkbox"/> DISCHARGED <input type="checkbox"/> DIED <input type="checkbox"/> STILL PATIENT	26. DATE DISCHARGED OR DIED
E. Occupational Therapy					27. COMPUTATION OF INTERIM PAYMENT	
F. Speech Therapy						
G. Pharmacy						
H. Other (Describe)						
I. TOTALS			\$			
17. Coinsurance      Days@			\$	Reimbursement Amount \$		
18. Part B Services Furnished to other than Inpatients			CHARGES	INTERMEDIARY USE		
			\$	VERIFIED PRIOR STAY DATES		
				28. QUALIFYING HOSPITAL      BEGINNING THRU      PROVIDER NUMBER		
TOTALS				28a. OTHER		
19. Part B Charges paid by Patient			\$	29. SEMI-PRIVATE DIFFERENTIAL \$		
32. I certify that the required Physician's certification and recertifications are on file.				30. PART B DEDUCTIBLE \$      30a. COINSURANCE \$      31. REFUND TO PATIENT \$		
SIGNATURE OF EXTENDED CARE FACILITY REPRESENTATIVE			DATE FWD.	33. APPROVED BY      DATE		



a spell of illness has begun, all subsequent hospital and extended care facility stays must be reported to the Social Security Administration, regardless of whether hospital insurance benefits are payable for such stays.

Specifically, the extended care facility should submit a billing form:

- for the period from the date benefits were exhausted until the patient's discharge or death;
- for the period beginning with the fourth day after a utilization review notice (concerning the lack of medical need for further extended care facility services) is received, and ending with the date of discharge or death;
- for the period for which payment was made or can be expected to be made by a workmen's compensation plan;
- for an inpatient extended care facility stay when the 3-day prior hospital stay and the 14-day transfer requirements were not met, or where the services were not covered for some other reason (e.g., the physician did not believe that extended care services were required for a condition for which the patient received hospital treatment).

Only one bill is required in a no-payment case, and that bill should be submitted at the time of the patient's discharge or death. When an extended care facility submits a billing form in one of these cases where no payment can be made, only the following items on the billing form should be completed: Items 1, 2, 6, 7, 9, 10, 14, 15, 16I, 18, 20, 25, 26, and 32. (The statement concerning certification in item 32 should be crossed out.)

A brief explanation should be entered in item 27 giving the reason no payment can be made.

**405.1 Submitting Bills in No-Payment Cases Where Utilization Is Chargeable.**—If the patient refuses to sign a payment request (Form SSA-1478 or substitute form provided by the facility), no program payment can be made to the facility, but the stay must be counted against the patient's 100 benefit days.

Thus, a bill must be submitted in these cases upon the patient's discharge or death. (See § 306 on submitting the admission notice.) All items on the bill should be completed. "Refused payment" should be shown in item 27. The facility may bill the patient for services.

If, in these "refused payment" cases a payment request is later signed, the facility should make a copy of the original bill and send it to the intermediary. The facility will make appropriate refund to the patient. In item 27, the reason for no payment on the original bill should be crossed out, and the notation "patient requested payment" should be entered.

Cases in which a physician refuses to sign a certification, even though he agrees that extended care services are required, will be handled in the same way. However the facility may not bill the patient for any covered services, since its agreement with the Secretary precludes it from doing so. The appropriate remarks are "refused certification" and "physician certification obtained."

#### **406. PROCEDURES FOR SUBMITTING CORRECTED BILLS**

The facility may discover that a bill already submitted is incorrect. No action need be taken when the total charges are not changed by more than \$10, or the interim cost reimbursement by more than \$1, unless the number of inpatient days, or a Part B charge, is changed.

To correct a previously submitted bill, the extended care facility should reproduce a legible copy of the submitted bill. Any necessary corrections should be made in red in the appropriate item. The corrected bill should be marked "DEBIT-ADJ." in the upper right-hand margin. If all charges and days reported on the previously submitted bill are to be deleted, mark it "CANCEL ONLY" in the upper right-hand margin. Send this corrected bill to the intermediary.



3000 - Definitions

3100 - Coverage of Services

3200 - Amounts

3300 - Requirements for Payments





600-4D  
7102  
24423  
71012-3



# EXTENDED CARE FACILITY MANUAL REVISION

U.S. DEPARTMENT OF  
HEALTH, EDUCATION, AND WELFARE  
SOCIAL SECURITY ADMINISTRATION  
HIM-12

HEALTH INSURANCE FOR THE AGED

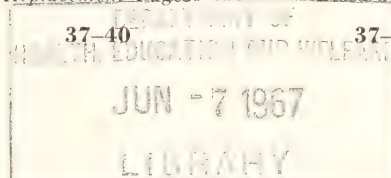
MAY 1967

NO. 3

## New Material

Sec. 303 — 399

Replacement Pages... Discard Pages



**Section 303, Admission Notice.**—A paragraph has been added to take note of the fact that reports of eligibility to hospitals include data about the patient's eligibility for extended care facility benefits. Where there is a question about the patient's entitlement and eligibility for extended care facility benefits, or the intermediary's reply is delayed, the facility may ask the transferring hospital for the information. However, the facility should not submit a bill before receipt of the report of eligibility.

**Section 303.2, Explanation of Admission Notice Entries, Item 12.**—A facility having only private accommodations can be paid only the equivalent of the reasonable cost of semiprivate accommodations unless the private accommodations were medically necessary. In completing this item, such a facility should use *the equivalent semiprivate rate* as determined by the intermediary rather than *the most prevalent semiprivate rate* when a private room was not medically necessary.

Thomas M. Tierney, Director  
Bureau of Health Insurance

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or  
☐ = Line on which change ends

Revision transmittal sheets should be filed at the end of the manual as a record of receipt.





### 303. ADMISSION NOTICE

A participating hospital can receive payments for a specified number of days under the hospital insurance program for inpatient services furnished a beneficiary in good faith during the period preceding receipt of the intermediary's report of eligibility, even though that report shows that as of the time of its receipt by the hospital the beneficiary's entitlement to inpatient hospital services has been exhausted for the current spell of illness. However, there is no such guarantee of payment provision in the law for extended care facilities. It is important that the extended care facility admission notice be sent as soon as possible, so that a speedy report on the patient's eligibility may be given to the facility.

The facility, of course, may ask the transferring hospital for information about the patient's entitlement and eligibility for ECF benefits, without waiting for the intermediary's report of eligibility, in cases where the facility believes there may be some question about this, or if the intermediary reply is delayed. (The report of eligibility to the hospital includes data about the patient's eligibility for ECF benefits.) In such cases, however, the facility should not submit a bill until the intermediary's report of eligibility is received.

The admission notice (see Exhibit 3) data sent to the intermediary should include the information called for in items 1 through 14 of the form SSA-1478; except that where item 12 applies, its completion may be delayed until the bill is submitted. The bottom two copies of the form SSA-1478 are the admission notice copies. Depending on the arrangements made with the intermediary or the social security district office, the facility may send the admission notice copies of the billing form by mail or messenger, or may submit the information from these forms by wire or telephone.

**303.1 Completing Admission Notices.**—The hospital transfer form should show the patient's name and address; health insurance claim number; dates of hospital stay; welfare agency name, address, and case number, if applicable; and a notation indicating workmen's compensation, if any. The facility should rely on this information in completing items 1, 2, 3, 5, 10, 11, and 14 of the form SSA-1478. (Additional information from the patient or hospital may be required to complete items 10 and 11.)

All entries on the form should be typed. Show month, day, and year entries in 6-digit numbers, e.g., 07/09/67.

### 303.2 Explanation of Admission Notice Entries

**Item 1. Patient's Name.**—The patient's name should be the same as that shown on the hospital transfer form or on his health insurance card, with the last name first.

**Item 2. Health Insurance Claim Number.**—Enter the health insurance claim number as shown on the hospital transfer form, the patient's health insurance card, utilization notices, the temporary eligibility notice, or as reported by the social security district office.

**Item 3. Patient's Address.**—Enter the patient's mailing address.

**Item 4. Attending Physician.**—Enter the name of the physician who is expected to certify the medical necessity of the extended care facility stay.

**Item 5. Dates of Prior Hospital Stay.**—Enter the dates of stay in the hospital from which the patient was most recently discharged after a stay of at least 3 days. If the facility does not have in its files a hospital transfer form showing these dates, or a written report of a telephone conversation with the hospital in which these dates were furnished, then the facility should not complete item 5. If item 5 is not completed attach an explanation to the admission notice. The transferring hospital's name and address should be shown in item 11, and the intermediary will verify the prior-stay dates and enter them on the billing form.

**Items 6 and 7. Provider Identification and Provider Number.**—Enter the name and address of the extended care facility and the assigned health insurance provider number. This information may be pre-printed or stamped on all copies of the form, if desired.

**Item 8. Medical Record Number.**—Enter the number, if any, used by the facility to identify the patient's medical record.

**Item 9. Date of Admission.**—Enter the date of the current admission in 6-digit numbers; e.g., 09/07/67. Show the actual date of admission even though this was before January 1, 1967.

**Item 10. Payment Source.**—Indicate who will pay for any services to the patient which will not be paid for by the health insurance program. More than one source may be checked, if applicable. If State public welfare agency payments will be made, show the name and address of the agency and the patient's case number, if known.

**Item 11. Names and Addresses of Prior-Stay Institutions.**—Enter **first** the name and address of the hospital from which the patient was most recently discharged, after a stay of at least 3 days. The first entry in item 11 should always be the name and address of the hospital to which item 5 refers.

Next enter the name and address of any extended care facility the patient entered in the period between his discharge from the hospital item 5 refers to, and his current facility admission. Also, enter the name and address of any hospital the patient may have entered in this period for a stay of less than 3 days.

The last entries in item 11 should be the names and addresses of any hospital or extended care facility (not already listed) from which the patient was discharged in the 60-day period before the date of admission to the prior-stay hospital in item 5. This information is needed by the intermediary to determine the number of inpatient extended care facility benefit days for which the patient is eligible in the current spell of illness.

Prior-stay institutions should be listed in this item regardless of whether they are participating in the health insurance program.

**Item 12. If the Patient Received Accommodations Other Than Semi-private, Explain the Reason Why.**—This item needs to be completed only if the patient is being assigned to accommodations other than semi-private. If item 12 is not completed at the time of admission, and other than semi-private accommodations are furnished at a later date, item 12 should be completed when the bill is submitted.

If the patient is furnished private accommodations, check the appropriate block indicating the reason for this (patient's request, medical necessity, other reason). If the "medical necessity" or "other reason" block is checked, type a brief explanation in this item.

If private accommodations were medically necessary, the program will pay the reasonable cost of these accommodations. If a private room was furnished at the patient's request, the program will cover only the cost of a semi-private room, and the patient is responsible for the difference between the customary private room charges, and the most prevalent customary semi-private room charges at the time of admission. If the patient was furnished a private room and this was not at his request nor medically necessary, the program will pay only the cost of the most prevalent semi-private accommodations at that time; **and** the patient may not be charged any additional amount. (See § 212.2A and B.)

If the patient requested a private room, show the most prevalent charge for semi-private accommodations in item 12.

If the patient is furnished ward accommodations, check the appropriate block indicating whether this was done at the patient's request or for another reason. If the "other reason" block is checked, type a brief explanation in this item. Then enter, in the space provided, the amount representing the most prevalent charge for semi-private accommodations in the facility at the time of admission. If the patient is assigned to a ward, and this was not at his request nor for a reason which the intermediary determines is consistent with program purposes, reimbursement to the facility will be based on the cost of semi-private accommodations minus the difference between the customary semi-private charges at the most prevalent rate and customary ward charges. (See § 212.2C.)

To determine the most prevalent charge for semi-private accommodations:

- (1) Type of accommodation.
- (2) Total rooms of each type, for each different room rate.
- (3) Total beds found in each type for each room rate.
- (4) Rate you charge daily for the type of room.
- (5) Your most prevalent charge for semi-private accommodations is that single rate that you charge for the largest entry appearing under your "total beds" column.

#### Example:

(1) Type of accommodation	(2) Total rooms of this type	(3) Total beds col. (1) x col. (2)	(4) Rate per day
2 beds.....	10	<b>20</b>	<b>\$14.00</b>
2 beds.....	8	16	15.00
3 beds.....	2	6	12.00
4 beds.....	1	4	9.00

*Note:* \$14.00 is the most prevalent semi-private charge.

When the facility is one which has only private accommodations, the most prevalent semi-private accommodation rate is not applicable. In such a case, the facility will use the equivalent semi-private rate established by the intermediary in place of the most prevalent semi-private rate.



**Item 13. Patient's Certification and Payment Request.**—Have the patient or his authorized representative read the statement on the form or the statement in the facility's admission record if the facility uses the alternate signature procedure (see § 250.2). If the facility obtains the signature on its own form, the signature line of the original of form SSA-1478 should be stamped to indicate that the "Patient's request for payment is on file." If the signature is obtained on form SSA-1478, it is sufficient if it is legible on the original only.

If the patient cannot sign his name because of his physical or mental condition, another person may sign on his behalf; e.g., John J. Jones by Jack A. Smith. In certain situations, a facility representative may sign on behalf of the patient. (See § 251 for who may file a payment request.)

Briefly explain the reason why the patient did not sign the form himself and show the relationship of the signer to the patient. This explanation should be retained in the facility's file if the signature is obtained on the facility's own record. If the signature is on form SSA-1478, the explanation should accompany or be included on the billing form.

The statement should be read to the patient who signs by mark. The signature by mark should be witnessed by a person who knows the patient. Enter the name and address of any person witnessing the signature by mark.

**Item 14. Admitting Diagnoses.**—Enter the primary and secondary diagnoses. The physician's certification will indicate that inpatient extended care services are required for a condition for which the patient was receiving inpatient hospital services. Use standard nomenclature from "Standard Nomenclature of Diseases and Operations," "Current Medical Terminology, Surgical Section," and "Current Procedural Terminology."

Check the appropriate block indicating whether a workmen's compensation claim is involved. (See § 258.)

### 304. REPLY TO NOTICE OF ADMISSION

The bottom portions of the admission copies of form SSA-1478 are designed to provide eligibility information in response to the extended care facility admission notices. (See Exhibit 3.) The intermediary may use the form for this purpose, or may give the eligibility information to the facility by wire or telephone, depending upon the arrangements made between the facility and the intermediary. The direct-dealing extended care facility will receive a form reply (form

SSA-1568) to the Notice of Admission from Bureau of Health Insurance, Direct Reimbursement Branch, Baltimore, Maryland.

Whether the reply is given by mail, telephone, or wire to the facility, it will contain the following eligibility information called for on the "Report of Eligibility" portion of the admission notice:

**A. Effective Date—Hospital Insurance.**—The month and year of the patient's entitlement to hospital insurance benefits (Part A) will be shown. If not entitled, the entry will so indicate.

**B. Effective Date—Medical Insurance.**—This will show the month and year of the patient's entitlement to medical insurance (Part B). The entry will so indicate if the patient is not entitled to Part B benefits.

**C. ECF Days Remaining.**—The number of extended care facility days for which payment can be made in full for the current spell of illness will be shown in the "Full" block. The number of days remaining, for which the patient must pay the coinsurance amount, will be shown in the "Coinsurance" block. "None" will be shown where applicable.

**D. Pints Remaining—Blood Deductible.**—This item is for informational purposes.

**E. 3-Day Hospital Stay Requirement.**—The intermediary will complete this item to show whether this requirement is "Met" or "Not Met."

**F. 14-Day Transfer Requirement.**—The intermediary will complete this item to show whether the 14-day requirement is "Met" or "Not Met."

**G. HHA Visits Remaining—Hospital Insurance and Medical Insurance.**—The number of home health visits remaining under Part A will be shown. Remaining home health visits under Part B will not be routinely shown in replying to extended care facility Notices of Admission.

**H. Medical Plan Deductible.**—The status of this deductible will be indicated by a checkmark in the block designated "Met" or "Not Met." If the deductible is not met, the amount remaining to be met will not be shown. If the reply shows the deductible is "Not Met," and Part B services have been furnished, the extended care facility should ask the patient whether he has had any previous Part B expenses which could be counted toward the deductible. (See § 115.3.) The facility should try to determine whether the patient has satisfied the Part B deductible before charging him this amount.



The intermediary will determine the patient's exact Part B deductible status upon receipt of the facility's bill.

**I. Open Item Information.**—The information in this block will be completed by the intermediary when verifying reports of "extended care facility open items" (admissions recorded in SSA central records, but not closed out by processing of a bill).

Where there is an extended care facility open item reported from the SSA central record, this "open item" must be processed before the current bill can be processed. The intermediary (or the SSA Direct Reimbursement Branch in the case of a direct-dealing provider) will get in touch with the "open item" provider to verify the stay, the date of the prior discharge, and status of the bill. The intermediary will use the prior stay information to compute the remaining days of eligibility.

**Remarks.**—Any necessary explanation of eligibility information will be shown. This will include corrections in the name or health insurance claim number reported by the facility. When changes of this sort are reported, the name and claim number information on the billing form should be changed accordingly.

If name and claim number information were not matched, the intermediary will request the facility to verify the claim number. (See § 302.4.)

### **305. RETROACTIVE ENTITLEMENT**

It may happen that an individual over 65 years of age does not establish his entitlement to hospital insurance benefits until after his discharge from an extended care facility. In such a case, payment may be made for extended care service furnished in a retroactive period of up to 12 months, but not before January 1, 1967. When a beneficiary inquires about retroactive entitlement, he will usually have a Social Security Administration notice which prompted his inquiry. In these cases, the facility should follow the Notice of Admission procedure to verify the patient's eligibility. When this is verified, the facility should refund to the patient any payments he made for services which are

covered by the program, and submit a bill to the intermediary.

### **306. INITIATING NOTICES OF ADMISSION WHERE NO PAYMENT WILL BE MADE**

§ 405 explains that extended care facilities will submit billing forms even when no payments under the program may be made. In most such cases, Notices of Admission will have been initiated as a normal course of procedure to determine the patient's eligibility. However, there will be some situations where, at admission, the individual states that benefits have been exhausted in the current spell of illness. The extended care facility should nevertheless initiate a Notice of Admission. This notice will serve to verify that the patient has in fact no remaining eligibility, and also help to keep the beneficiary's utilization record current.

Notices of Admission should also be sent even though workmen's compensation has paid or can be expected to pay the entire bill, the services are not covered, the 3-day hospital stay and 14-day transfer requirement are not met, or the patient refuses to request payment.

Where the patient refuses to request payment and does not furnish his health insurance claim number, the facility should get in touch with the SSA district office for assistance in obtaining this number. If the patient refuses to request payment which could otherwise be made on his behalf, his utilization record must nevertheless be charged for covered extended care services furnished him.

After the report of eligibility is received in such no-payment cases, billing forms should be forwarded, to keep the patient's utilization record current, in accordance with § 405.

### **399. EXHIBITS**

Exhibit 1. Health Insurance Cards and Claim Numbers

Exhibit 2. Temporary Eligibility Notice

Exhibit 3. Extended Care Admission and Billing (Admission Copy)—Form SSA-1478

3000 - Definitions

3100 - Coverage of Services

3200 - Amounts

3300 - Requirements for Payment

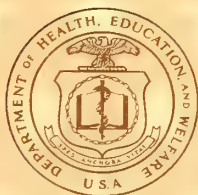




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**HEALTH  
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**EXTENDED  
CARE FACILITY  
MANUAL**



U.S. DEPARTMENT OF  
HEALTH, EDUCATION, AND WELFARE  
SOCIAL SECURITY ADMINISTRATION

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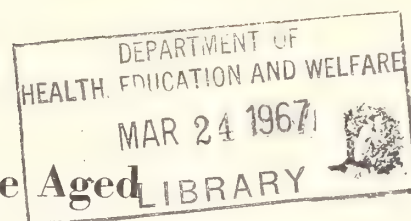
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## Health Insurance for the Aged

# EXTENDED CARE FACILITY MANUAL

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### USING THE EXTENDED CARE FACILITY MANUAL

#### *Use It for Reference*

The manual covers not only routine information for your day-to-day operations but tries to anticipate infrequent situations that could occur. It has been indexed for ease of reference.

#### *Keep It Available*

Pages are punched for any standard-size three-ring binder. Keep it handy and ask for as many extra copies as you need.

#### *Keep It Up-to-Date*

Insert or replacement pages and supplements for additions and revisions will be furnished through your intermediary. Maintain a control on all manuals to assure immediate updating.



## FOREWORD

This manual is designed for use by extended care facilities which will be billing for services furnished under the provisions of the Health Insurance for the Aged Act of 1965. It contains informational and procedural material the facility will need to assist in prompt and efficient payment of claims and to answer questions which patients may ask about the program. This issuance should help to assure that the law is uniformly applied nationally without regard to where covered services are furnished. The facility's intermediary will issue any necessary additional instructions on matters which concern the relationship between facilities and intermediaries.

The manual does not have the effect of regulations, but a careful effort has been made to insure that the provisions of the law and proposed regulations are accurately reflected.

The procedures described in this manual have been devised to satisfy the administrative needs of the program with a minimum of inconvenience to beneficiaries, and to extended care facilities and their intermediaries. We believe that the vast majority of claims will lend themselves to simple, routine handling.

The manual is designed to accommodate new pages as further interpretations of the law and changes in procedures are made. Accordingly, supplements, and revised sections, pages or chapters will be issued as the need presents itself.

Your intermediary will answer any questions you may have about policies and procedures in the program. Extended care facilities dealing directly with the Social Security Administration may direct questions to the servicing social security district office for reply or refer them to the Bureau of Health Insurance Regional Representative.

ARTHUR E. HESS  
*Director, Bureau of Health Insurance*

## Chapter I

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## Chapter I

### GENERAL INFORMATION ABOUT THE PROGRAM

#### 100. INTRODUCTION

The Health Insurance for the Aged Act, Title XVIII of the Social Security Act, has made available to nearly every American 65 years of age and older a broad program of health insurance designed to assist the Nation's elderly to meet hospital, medical, and other health costs. The program includes two related health insurance programs—hospital insurance (Part A of the law) and voluntary supplementary medical insurance (Part B of the law).

The conduct of the program has been delegated by the Secretary of Health, Education, and Welfare, to the Commissioner of Social Security. Congress has provided substantial administrative roles for the States and for voluntary insurance organizations in recognition of their experience in the health care and insurance fields.

The law specifically prohibits the Federal Government from exercising supervision or control over the practice of medicine, the manner in which medical services are provided, and the administration or operation of medical facilities. The patient is free to choose any qualified institution, agency, or person offering him services. The responsibility for his treatment and the control of his care remains with his physician and the hospital, facility, or agency furnishing him services. The individual may keep or obtain any other health insurance he desires.

#### 102. DISCRIMINATION PROHIBITED

Participating providers of services under the hospital insurance program, i.e., hospitals, extended care facilities, and home health agencies, must comply with the requirements of Title VI of the Civil Rights Act of 1964. Under the provisions of that Act a participating extended care facility is prohibited from making a distinction on the ground of race, color, or national origin in the admission and treatment of patients; the accommodations provided; the use of equipment and other facilities; and the assignment of personnel to provide services.

The Department of Health, Education, and Welfare

is responsible for investigating complaints of noncompliance.

#### 104. DISCLOSURE OF INFORMATION

Records and information acquired in the administration of the Social Security Act are confidential and may be disclosed only under the conditions prescribed in regulations or on the express authorization of the Commissioner of Social Security. The regulations of the Department of Health, Education, and Welfare regarding the confidentiality of records and information apply not only to governmental agencies, but also to public and private agencies participating in the administration of the program as well as those institutions, facilities, agencies, and persons providing services, and those furnishing services under arrangements with a provider of services.

However, the information in the provider's medical records of a patient (except for information therein furnished specifically for purposes of a claim under the program—such as the individual's health insurance claim number, the fact of his entitlement to health insurance benefits, and medical and other information obtained from the Social Security Administration or an intermediary, etc.) is not subject to these rules and regulations even though the patient receives benefits under this program. These records, however, may be subject to State or local laws or extended care facility rules governing disclosure, and are subject to the requirement of confidentiality in the "Conditions of Participation for Extended Care Facilities."

Disclosure by a provider of records or information acquired under the health insurance program is permitted only when the record or information is to be used in connection with a claim for health insurance benefits and such disclosure is necessary for the proper performance of the duties of any officer or employee of the Department of Health, Education, and Welfare, or for the proper performance of the duties in administration of the health insurance program of any officer or employee of a public or private agency or organization which has entered into an agreement with the Secretary of Health,

Education, and Welfare to perform certain administrative functions under the program.

Program information furnished by an extended care facility to a State agency certifying providers in the health insurance program may, with the approval of the Department of Health, Education, and Welfare, be disclosed by the State agency to the State licensing authority if the information relates to the provider's compliance or noncompliance with the licensure requirements.

Health insurance information may not be disclosed by extended care facilities, other than as described above, except under the conditions prescribed by regulations and in accordance with procedures established by the Social Security Administration. The Administration has issued guidelines to be used by intermediaries in making arrangements with State welfare agencies for the release of billing information to the welfare agencies in those cases in which payment of the cost of extended care services is to be made both under the health insurance program and the State welfare program. Where State agencies have entered into agreements with health insurance intermediaries, implementation of the procedures will depend upon the State welfare agencies making the necessary arrangements with the facility involved.

## **110. HOSPITAL INSURANCE—A BRIEF DESCRIPTION**

This is the basic part of the health insurance program and is designed to help patients defray the expenses incurred by hospitalization and related care. In addition to inpatient hospital benefits, hospital insurance covers outpatient hospital diagnostic services, posthospital care in extended care facilities, and in the patient's home by home health agencies. In providing these benefits, recognition was given to the need for continued treatment after hospitalization and the need to encourage the use of less expensive substitutes for inpatient hospital care. Program payment for services rendered to beneficiaries by providers (i.e., hospitals, extended care facilities, and home health agencies) may be made only to the provider, and is based on the reasonable cost of the covered services furnished.

**110.1 Posthospital Extended Care Services.**—Coverage of extended care services is provided under hospital insurance. The definition of the extended care facility, requirements for coverage, a description of extended care benefits, and the applicable coinsurance, limitations and exclusions are fully treated in Chapter II.

**110.2 Inpatient Hospital Services.**—The items

and services covered include: bed and board in a semi-private (2 to 4 beds) accommodation, unless a private room is medically necessary; nursing and other related services; use of hospital facilities and medical social services ordinarily furnished by the hospital for the care and treatment of inpatients; drugs, biologicals, supplies, appliances, and equipment for use in the hospital, which are ordinarily furnished by the hospital; diagnostic or other therapeutic items or services furnished by the hospital or by others under arrangements made by the hospital; services by interns or residents-in-training if they are under a teaching program approved by the American Medical Association, American Osteopathic Association, or American Dental Association; and cost of whole blood after the first 3 pints in a spell of illness and all costs of administering the blood including the provider's costs of administering the first 3 pints.

The patient is entitled to payment on his behalf for up to 90 days of inpatient hospital services in each spell of illness. There is an inpatient hospital deductible of \$40 in each spell of illness and a coinsurance amount of \$10 per day after the 60th day and through the 90th day. The deductible and coinsurance amounts are subject to change on January 1, 1969, and on the first day of each year thereafter.

Inpatient tuberculosis hospital services are covered if the services furnished to the individual are services which can reasonably be expected to improve his condition or render it noncommunicable. Inpatient psychiatric hospital services are covered if the services furnished to the patient are furnished when he is receiving intensive treatment, or are necessary for medically required inpatient diagnostic study. Where an individual is in a qualified tuberculosis or psychiatric hospital on the first day of the first month for which he is entitled to hospital insurance benefits, the days on which he was an inpatient of such a hospital in the 90-day period immediately before his first day of entitlement must be counted in determining the 90-day limit on inpatient hospital services in his first spell of illness. In addition, there is a lifetime limitation of 190 days for payment for inpatient psychiatric hospital services. A period spent in a psychiatric hospital prior to entitlement, however, does not count against the 190 days.

**110.3 Outpatient Hospital Diagnostic Services.**—Outpatient hospital diagnostic services covered under hospital insurance include—

A. diagnostic tests and related services to the extent that they would not be excluded if performed on an inpatient basis;



B. drugs and biologicals necessary for diagnostic study;

C. the services rendered in connection with a diagnostic study by an intern or resident-in-training under an approved teaching program; and

D. other services and supplies if customarily furnished to outpatients for purposes of diagnostic study.

Benefits are payable on the basis of a diagnostic study period, which is a period of 20 consecutive days beginning with the first day, not included in a previous diagnostic study, on which the patient receives outpatient diagnostic services.

The **deductible** for outpatient hospital diagnostic services during each diagnostic study is one-half the inpatient hospital deductible, or \$20. This deductible amount counts as an incurred expense for individuals with supplementary medical insurance coverage. After satisfying the \$20 deductible, the patient is responsible for a coinsurance amount equal to 20 percent of the reasonable charges, not in excess of the amount customarily charged, for the outpatient hospital diagnostic services rendered during the diagnostic study.

#### **110.4 Posthospital Home Health Services.—**

Home health services under hospital insurance include up to 100 home health visits after the beginning of one spell of illness and before the beginning of the next furnished a patient within one year of his most recent discharge from a hospital of which he was an inpatient for at least 3 consecutive calendar days. If, after his hospitalization, he had a covered stay in an extended care facility, the 1 year during which the patient may receive home health services begins with the discharge from the extended care facility. A plan of treatment must be established within 14 days after the hospital or extended care facility discharge. Home health services are provided also under supplementary medical insurance. (For the latter, see § 115.1.)

The patient receiving posthospital home health services must be under the care of a physician who must establish and periodically review the plan for his patient's care. To be covered the services must be required by a condition for which the patient required inpatient hospital services or extended care services and the patient must be confined to his home. Discharge from the period of hospitalization required for home health services must occur after June 30, 1966, or on or after the first day of the month in which the patient attains age 65, whichever is later.

Home health services are services provided by a home health agency or by others under arrangements with such an agency. A home health agency is a public or private organization which is primarily engaged

in providing skilled nursing and other therapeutic services. Where applicable, the agency must be licensed under State or local law, or be approved by the State or local licensing agency as meeting the licensing standards. Examples of home health agencies are visiting nurse associations, official health agencies, and hospital-based home care programs. To participate in the health insurance program a home health agency must meet certain other requirements included in the law as well as health and safety conditions prescribed by the Secretary of Health, Education, and Welfare. It may not qualify under hospital insurance, however, if it is primarily engaged in the treatment of mental diseases.

These services are usually furnished on a visiting basis in a place of residence used as the individual's home. However, outpatient services in a hospital, extended care facility, or rehabilitation center are covered home health services, if arranged for by a home health agency, when equipment is required that cannot be made available in the patient's home.

Covered home health services include part-time nursing care by or under the supervision of a registered professional nurse; physical, occupational, or speech therapy; medical social services; certain services of a home health aide; medical supplies (other than drugs and biologicals); and the use of medical appliances. The costs of housekeepers, food service arrangements, and transportation to outpatient facilities are excluded as home health services.

The services of an intern or resident-in-training are covered if the agency and hospital are affiliated or under common control and the agency bills for the services.

### **115. SUPPLEMENTARY MEDICAL INSURANCE—A BRIEF DESCRIPTION**

**115.1 Benefits.**—The voluntary medical insurance plan is designed to supplement the basic hospital insurance coverage. It provides coverage effective July 1, 1966, for (a) home health visits and (b) medical and other health services.

A. Medical insurance covers home health services for up to 100 visits during the calendar year (in addition to the visits covered under hospital insurance) but without the requirement of prior inpatient hospital care.

B. Medical and other health services include:

1. Physicians' services (see definition of "physician" below) including surgery, consultation, and home, office, and institutional calls.

Regardless of the actual expenses for physician serv-



ices incurred in the treatment of mental, psychoneurotic, or personality disorders of persons who are not inpatients of hospitals, the amount of such expenses that can be counted in a calendar year is limited to the lesser of \$312.50 or 62.5 percent of the actual expenses.

**Physician** means a doctor of medicine or osteopathy (including osteopathic practitioner) legally authorized to practice by a State in which he performs the function or action. A doctor of dental surgery or dental medicine having State authorization to practice is also defined as a physician but only for surgery related to the jaw or any structure contiguous to the jaw, or the reduction of a fracture of the jaw or any facial bone. (These services must be services that could be performed by either a qualified physician or dentist; routine dental care is not included.) The services performed by physicians within these definitions are subject to any limitations imposed by the State on the scope of practice.

2. Services and supplies (including drugs and biologicals which cannot be self-administered) incident to physicians' professional services and of kinds commonly furnished by a physician in his office and which are commonly rendered without charge or included in his bill, and hospital services incident to physicians' services rendered to outpatients.

3. Diagnostic X-ray, laboratory, and other diagnostic tests unless furnished as outpatient hospital services to patients having Part A coverage.

4. X-ray, radium, and radioactive isotope therapy (including material and services of technicians).

5. Surgical dressings, and splints, casts, and other devices used for reduction of fractures and dislocations.

6. Rental (for use in the patient's residence, including an institution used as his home) of such durable medical equipment as iron lungs, oxygen tents, wheelchairs, and special beds.

7. Ambulance service, where the use of other transportation is contraindicated by the patient's condition.

8. Prosthetic devices (other than dental) replacing all or part of an internal body organ, including replacement of such devices.

9. Leg, arm, back, and neck braces, and artificial legs, arms, and eyes, including replacements if required because of a change in physical condition.

**115.2 Basis for Payment.**—Payment, based on **reasonable charges**, may be made to or on behalf of individuals covered by medical insurance for services of physicians and other nonprovider services furnished under the plan. In determining the reasonableness of charges, the carrier takes into consideration the customary charges of the physician (or other person

rendering the service) as well as the prevailing charges in the locality generally made for similar services. A charge is not reasonable if it is higher than the charge applicable for a comparable service and under comparable circumstances to the intermediary's own policyholders or subscribers.

Payment for services covered by medical insurance and rendered by a hospital, extended care facility, or home health agency, or under arrangements made by such provider, is based on the reasonable cost of the services and is made only to the provider of services. This is the same basis for reimbursement as under the hospital insurance plan and accords with the provider's undertaking in the participation agreement to accept reasonable cost as full payment for services rendered.

**115.3 Deductible and Coinsurance.**—In each calendar year a deductible of \$50 must be satisfied before payment may be made under the supplementary medical insurance plan. Expenses applied toward the deductible in the last 3 months of a year may also be applied toward the deductible in the following year. After the deductible has been satisfied, payment by the supplementary medical insurance program will be made for 80 percent of the reasonable charge for physicians' and suppliers' services or reasonable cost of provider services.

## **120. ENTITLEMENT TO HOSPITAL INSURANCE**

A. An individual is **automatically** entitled to hospital insurance beginning with the first day of the month he attains age 65 if he has applied for and been determined to be entitled to monthly social security benefits (although he may not actually be receiving benefit payments, e.g., he has not retired). Automatic entitlement also extends to qualified beneficiaries under the Railroad Retirement Act. (For social security purposes, a person attains age 65 on the day before his 65th birthday.) Example: If birth date is August 1, attainment date is July 31, and health insurance entitlement date is July 1.

A social security applicant who applies for monthly benefits after the month he reaches age 65 is entitled to retroactive hospital insurance benefits beginning with the first month in which he had attained age 65 and met all the requirements for monthly benefits, but not for more than 12 months before the month in which he filed his application.

Entitlement to hospital insurance benefits ends with the month the individual ceases to be entitled to social security monthly benefits or ceases to be a qualified railroad beneficiary (for example, a woman whose wife's benefits are terminated by divorce). A person

who ceases to be a social security or railroad retirement beneficiary but who meets the requirements of the special transitional provision described below may reinstate his hospital insurance by filing a proper application under the transitional provision.

Hospital insurance coverage continues for the month of death, although no monthly cash benefits are payable for that month.

B. A special **transitional** provision in the law permits persons 65 years of age and over, who cannot qualify for monthly social security or railroad retirement benefits, to obtain hospital insurance upon filing application. Such an individual must be a resident of the United States and either a citizen, or an alien lawfully admitted for permanent residence who has resided in the United States continuously for 5 years. He may not be an active or retired Federal employee (or spouse of one) who is or could have been covered by the Federal Employees Health Benefit Act of 1959. He may not be a member of a communist organization nor have been convicted of a crime against the security of the United States.

For coverage under the transitional provision, a person attaining age 65 after 1967 must have three quarters of coverage for each year elapsing between 1965 and the year in which he attains age 65.

Hospital insurance under the transitional provision can also be retroactive for as many as 12 months before the month of application, provided the individual meets all the other requirements during the period of retroactivity.

## **122. ENTITLEMENT TO SUPPLEMENTARY MEDICAL INSURANCE**

A. **Enrollment.**—To obtain supplementary medical insurance coverage an individual must voluntarily enroll in the plan and pay the required premiums. He may enroll if he is entitled to hospital insurance benefits or, if he is age 65, a resident of the United States, and either a citizen or an alien admitted for permanent residence. Active or retired Federal employees and their spouses are eligible to enroll whether or not covered under the Federal Employees Health Benefit Act. (For social security purposes an individual attains age 65 on the day before his 65th birthday.)

By agreement States may enroll in the supplementary medical insurance plan eligible individuals who are receiving money payments under certain public assistance programs. Such persons who are entitled to monthly social security or railroad retirement benefits may be included at the option of the State.

B. **Enrollment Periods.**—Enrollment is possible only during specified enrollment periods.

1. During the **initial general enrollment period** an opportunity to enroll was afforded to all eligible persons age 65 and over before March 1, 1966. This enrollment period ended May 31, 1966. (An eligible individual who for good cause failed to enroll before June 1, 1966, could have enrolled before October 1, 1966.)

2. For persons first eligible on or after March 1, 1966, the **initial enrollment period** is 7 months. It begins 3 calendar months before and ends 3 calendar months after the month in which the individual first meets all enrollment requirements.

3. **General enrollment periods** occur October 1 through December 31 of each odd-numbered year, beginning with 1967. Those who failed to enroll during their initial enrollment periods and those whose enrollment has terminated may enroll in these periods.

4. **States which desire to enroll eligible individuals receiving public assistance** must request coverage before January 1968, and enter into an agreement with the Government.

An individual who fails to enroll for medical insurance within the 3-year period after the close of his initial enrollment period may not enroll thereafter.

An individual whose enrollment has terminated may re-enroll only once—in a general enrollment period which begins within 3 years after the termination of his prior enrollment.

Payment may be made for covered services if the individual was enrolled at the time the services were furnished, even though at the time the request for payment is filed with the intermediary his enrollment had been terminated.

**122.1 Premiums.**—Initially, the premium is \$3 per month. The law permits the Secretary of Health, Education, and Welfare to adjust the premium amount in accordance with changes in medical and other costs. No change in the premium is permitted before 1968, and changes thereafter can be no oftener than every 2 years. To take into account the higher cost of insuring older individuals, premiums payable by a person who enrolls after the first enrollment period open to him, or who re-enrolls after his initial enrollment was terminated, are increased by 10 percent for each full 12 months during which he could have been but was not enrolled.

A grace period has been provided for payment of premiums. This period extends 2 calendar months after the month in which the premium is due.

Persons enrolled for medical insurance and receiving social security, railroad retirement, or civil service



retirement benefits (except those enrolled by the State as public assistance recipients) will have the premiums withheld from their monthly checks. The State pays the premiums for the public assistance recipients it enrolls.

Other enrollees must make premium payments directly to the Social Security Administration. Enrollees who make direct premium payment will generally be billed quarterly. However, organizations, employers, unions, etc., may under certain conditions pay premiums for their members as a group.

### 122.2 Beginning of Coverage

A. Enrollment during the initial general enrollment period—coverage begins July 1, 1966. An individual who attained age 65 prior to March 1966, and who, on establishing good cause for failure to enroll timely, enrolled from June 1, 1966, through September 30, 1966, has coverage beginning the 1st day of the 6th month after the month in which he enrolled.

B. Enrollment during an entitled individual's initial enrollment period—coverage begins:

1. 1st day of the month in which the individual becomes age 65, if he enrolls **before** the month that he becomes age 65.

2. 1st day of the month following the month that he becomes age 65, if he enrolls **in** the month that he becomes age 65.

3. 1st day of the 2d month after the month of enrollment, if he enrolls in the month **after** he becomes age 65.

4. 1st day of the 3d month after the month of enrollment, if he enrolls **more than 1** month **after** the month in which he became age 65. (However, individuals who became age 65 in March 1966, and enrolled in May 1966, have coverage effective July 1, 1966.)

C. Enrollment during one of the general enrollment periods—coverage begins the following July 1st.

D. Enrollment by a State of its welfare recipients—coverage begins on the latest of the following but not later than January 1, 1968:

1. July 1, 1966;
2. 1st day of the 3d month after the month of the agreement with the State;
3. 1st day of the 1st month in which the individual is both eligible and a member of the group;
4. The date specified in the agreement.

### 122.3 End of Coverage

A. An individual whose medical insurance premiums are being deducted may notify the Social Security Administration in writing during a general enrollment period that he no longer wants medical insurance. His

coverage period will be terminated with the close of the year in which his notice is submitted.

B. Enrollment under medical insurance is terminated because of nonpayment of premiums. Termination is effective with the end of the grace period provided for payment of premiums.

C. If an individual is enrolled under a Federal-State agreement, his coverage under the agreement ends on whichever of the following first occurs:

1. The end of the month in which he becomes ineligible (as determined by the State) for welfare money payment; or

2. The end of the month before the first month for which he becomes entitled to monthly social security or railroad retirement benefits, unless the State exercises its option to enroll its welfare recipients who are entitled to such benefits.

If an individual's coverage under a Federal-State enrollment agreement is terminated, his coverage continues without interruption subject to the applicable premium payment requirements.

A social security or railroad retirement beneficiary who was enrolled under a State agreement and thereafter ceases to be a public assistance recipient may terminate his enrollment during the 3-month period after the month he leaves the public assistance rolls.

D. An individual will have coverage through the month in which he dies.

## 130. FEDERAL GOVERNMENT ADMINISTRATION OF THE HEALTH INSURANCE PROGRAM

The Department of Health, Education, and Welfare has been given overall responsibility for administration of the hospital insurance and voluntary supplementary medical insurance programs. Three major agencies of the Department—the Social Security Administration, Public Health Service, and Welfare Administration—are involved.

**130.1 The Social Security Administration** has the responsibility for policy formulation and the general management and operational aspects of the program. Briefly, these include: determination of the individual's entitlement to benefits and the nature and duration of services for which benefits may be paid; establishment, maintenance, and administration of agreements with State agencies, providers of services and intermediaries; in consultation with the Public Health Service and the Welfare Administration, the formulation of major policies regarding conditions of participation for providers; the development and maintenance of statistical research and actuarial pro-



grams; and the general fiscal management of the program. The Administration also makes determinations of reasonable costs and amounts to be paid to providers who have elected to deal directly with the Government.

**130.2 The Public Health Service** has the principal responsibility for the professional health aspects of the program. These include: professional consultation and recommendation to the Social Security Administration in development of health and safety, and other guidelines for determining whether providers of services meet the conditions for participation under the program; consultation and advice to State agencies concerning the application of standards for providers, and in the coordination of program activities with other health services and activities in the State; and activities necessary in studying the utilization of hospital and other medical care services under the program.

**130.3 The Welfare Administration** has the primary role in hospital and medical insurance program planning, coordination, and evaluation in matters that affect other federally aided assistance programs; in assisting State agencies to achieve a coordinated approach with other medical care plans under the Social Security Act; and in all aspects of program administration affecting public welfare agencies.

### **131. ADVISORY GROUPS**

The law provides for the appointment of two non-governmental advisory groups to assist the Secretary.

**131.1 The Health Insurance Benefits Advisory Council**, consisting of persons outstanding in hospital, medical, and other health activities, and at least one representative of the general public, advises the Secretary on general policy in administering the program and in the formulation of regulations. The Secretary must consult with the Council in determining conditions of participation for providers of services in addition to the requirements specifically enumerated in the law.

**131.2 The National Medical Review Committee** is to be selected from people who are representative of professional organizations and associations in the field of medicine and other individuals who are outstanding in the field of medicine or related fields. At least one member will represent the general public and a majority of the committee are to be physicians. The committee studies the utilization of hospital and other medical services under the program and makes any recommendations to the Secretary and to Congress that it considers appropriate.

## **132. STATE AGENCIES**

The States are accorded important administrative functions to the extent that each is willing and able to undertake them by agreement with the Secretary.

A. **Certifications** are made by State agencies to the Department of Health, Education, and Welfare indicating whether hospitals, extended care facilities, home health agencies, and independent laboratories meet and continue to meet their respective conditions of participation. This function is intended to be a natural adjunct to ongoing State activities, such as licensing of health facilities and other standard setting activities.

B. **Consultation** services are rendered by State agencies if their agreements provide for it. Consultation with hospitals, extended care facilities, and home health agencies that need and request assistance to meet the conditions of participation is an integral part of the certification process.

C. **Coordination** by the State relates its activities in the performance of its functions under the program to the various other programs in the State that have to do with payment for health care, quality of care, and distribution of health facilities. Coordination of such activities is designed to utilize existing State facilities and trained personnel effectively and economically and to prevent duplication of effort.

D. **State Agency as a Medical Insurance Intermediary.**—Where a State enters into an agreement with the Government to pay the medical insurance premium on behalf of its aged welfare recipients, as explained in § 122A of this chapter, the agreement may provide for a designated State agency to serve as an intermediary on behalf of its welfare recipients.

## **135. HOSPITAL INSURANCE INTERMEDIARIES**

Under the hospital insurance plan, groups, or associations of providers, on behalf of their members, may nominate a national, State, or other public or private agency, or organization to serve as intermediary in the claims process. A member of an association is free, however, to receive payment from an approved intermediary other than its association's nominee, if agreeable to the Social Security Administration and to the intermediary selected. A provider may deal directly with the Social Security Administration.

The law permits the Administration to enter into an agreement with a nominated organization if it finds this to be consistent with effective and efficient administration of the hospital insurance program. The inter-

mediary makes payments to providers for covered items and services on the basis of reasonable cost determinations and assists in the application of safeguards against unnecessary utilization of covered services. The agreement may also call for furnishing consultative services to assist providers to establish and maintain necessary fiscal records and otherwise qualify as providers of services; serving as a center for communicating with providers; and making audits of provider records.

Generally speaking, the Social Security Administration will utilize the services of the hospital insurance intermediary in making payments for provider services under medical insurance.

### **137. MEDICAL INSURANCE CARRIERS**

The law requires the Secretary to enter into contracts which carriers selected to serve as intermediaries for the performance of specified administrative functions under the medical insurance program. The principal function of this intermediary is to determine whether physicians' charges are reasonable and to make payment. Section 132.D. of this chapter explains the conditions under which a State agency may act as a supplementary medical insurance intermediary.

### **140. FINANCING HOSPITAL INSURANCE PROGRAM**

The hospital insurance program is financed through separate payroll contributions paid by employees, employers, and self-employed persons. The proceeds are earmarked for the Federal Hospital Insurance Trust Fund to keep them separate from other social security contributions. The law permits their use only for the payment of hospital insurance benefits and administrative expenses. The cost of providing hospital insurance benefits to persons who are not social security or railroad retirement beneficiaries is met by appropriations to the Federal Hospital Insurance Trust Fund from general revenues.

### **142. FINANCING SUPPLEMENTARY MEDICAL INSURANCE PROGRAM**

The supplementary medical insurance plan is financed by the monthly premiums of those who enroll under the plan, matched by an equal contribution from general revenues. All premiums and Government contributions for this plan are placed in a separate fund known as the Federal Supplementary Medical Insurance Trust Fund. This fund is devoted exclusively to the payment of medical insurance benefits and administrative expenses.

## Chapter II

### COVERAGE OF EXTENDED CARE FACILITY SERVICES

#### Definitions

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## Chapter II

### COVERAGE OF EXTENDED CARE FACILITY SERVICES

#### Definitions

#### 201. EXTENDED CARE FACILITY DEFINED

An extended care facility is an institution (or a distinct part of an institution, see § 201.1), such as a skilled nursing home or rehabilitation center, which has a transfer agreement in effect with one or more participating hospitals (see § 201.2 for transfer agreements and § 205 for definition of participating hospital), and which:

a. is primarily engaged in providing to inpatients skilled nursing care and related services for patients who require medical or nursing care, or rehabilitation services for the rehabilitation of injured, disabled, or sick persons,

b. has policies (developed with the advice of and periodically reviewed by a professional group including one or more physicians and one or more registered professional nurses) to govern the skilled nursing care and related medical or other services it provides,

c. has a physician, a registered professional nurse, or a medical staff responsible for the execution of such policies,

d. has a requirement that the health care of every patient must be under the supervision of a physician,

e. provides for having a physician available to furnish necessary medical care in cases of an emergency,

f. maintains clinical records on all patients,

g. provides 24-hour nursing service sufficient to meet nursing needs in accordance with the policies developed pursuant to (b) above, and has at least one registered professional nurse employed full time,

h. provides appropriate methods and procedures for dispensing and administering drugs and biologicals,

i. has in effect a utilization review plan,

j. is licensed in accordance with State or local law, or is approved by the State or local licensing agency as meeting the licensing standards where State or applicable local law provides for the licensing of institutions of this nature, **and**

k. is in substantial compliance with health and safety requirements established by regulation. (These

health and safety requirements are contained in the "Conditions of Participation for Extended Care Facilities.")

A **qualified** extended care facility is one which meets all the requirements in the above definition.

The term extended care facility does not include any institution which is primarily for the care and treatment of mental diseases or tuberculosis.

#### 201.1 A Distinct Part of an Institution as an Extended Care Facility.

—In order to qualify for participation in the program as an extended care facility, a distinct part of an institution must be physically separated from the rest of the institution, i.e., it must represent an entire, physically identifiable unit consisting of all the beds within that unit such as a separate building, floor, wing, or ward. Although it is required that the distinct part be identifiable as a separate unit within the institution, it need not necessarily be confined to a single location within the institution's physical plant. The distinct part may, for example, consist of several floors or wards which are scattered throughout several different buildings within the institutional complex. In each case, however, the patients of the distinct part would have to be located in units which are physically separate from those units housing all other patients of the institution. Various beds scattered throughout the institution would not comprise a distinct part for purposes of being certified as an extended care facility.

**201.2 Transfer Agreements.**—To participate in the program an extended care facility must have a written transfer agreement with one or more participating hospitals (see § 205) providing for the transfer of patients between the hospital and the facility, and for the interchange of medical and other information. If an otherwise qualified extended care facility has attempted in good faith, but without success, to enter into a transfer agreement, this requirement may be waived by the State agency. (See XIV of the "Conditions of Participation for Extended Care Facilities" (HIM-3) for the detailed requirements for transfer agreements.)



## 202. CHRISTIAN SCIENCE SANATORIUM

A **Christian Science sanatorium** operated or listed and certified by the First Church of Christ, Scientist, Boston, Mass., may qualify as both a **hospital** and **extended care facility**. There is provision for the payment of separate benefits in each case. Inpatient care in such an institution can begin or prolong a "spell of illness" (§ 220). Payment can be made in the same spell of illness for both inpatient hospital services furnished in a hospital and those furnished by a sanatorium in its capacity as a hospital, but the total days of covered care cannot exceed the maximum of 90 days in a spell of illness (§ 110.2).

Sanatorium services are considered to be furnished by a sanatorium in its capacity as a hospital unless the individual elects to have them treated as sanatorium extended care services.

Payment for sanatorium **extended care services** may be made **for up to 30 days** in each spell of illness, instead of the 100 days applicable to extended care services generally.

Payment may not be made for posthospital extended care services furnished to an inpatient of an extended care facility which is not a Christian Science sanatorium after he has been furnished, during the same spell of illness, covered sanatorium extended care services. Similarly, payment may not be made on behalf of an individual for sanatorium extended care services furnished him after he has been furnished posthospital extended care services during the same spell of illness as an inpatient of a qualified extended care facility which is not a Christian Science sanatorium.

## 203. HOSPITAL DEFINED

A **Hospital (Other Than Tuberculosis or Psychiatric)** is an institution which:

a. is primarily engaged in providing to inpatients, by or under the supervision of physicians,

(1) diagnostic and therapeutic services for medical diagnosis, treatment, and care of injured, disabled, or sick persons, or

(2) rehabilitation services for the rehabilitation of injured, disabled, or sick persons;

b. maintains clinical records on all patients;

c. has bylaws in effect concerning its staff of physicians;

d. requires that every patient must be under the care of a physician;

e. provides 24-hour nursing service by or supervised by a registered professional nurse, and has a licensed practical nurse or registered professional nurse on duty at all times;

f. has in effect a hospital utilization review plan;

g. is licensed or is approved by the State or local licensing agency as meeting the standards established for such licensing;

h. is in substantial compliance with other health and safety requirements of the Secretary of Health, Education, and Welfare. (These additional requirements may not be higher than comparable ones prescribed for accreditation by the Joint Commission on Accreditation of Hospitals with certain exceptions specified in the law.);

i. is not primarily for the care and treatment of mental diseases or tuberculosis.

**203.1 Psychiatric and Tuberculosis Hospitals.**—A psychiatric hospital is an institution which is primarily engaged in providing by or under the supervision of a physician, psychiatric services for the diagnosis and treatment of mentally ill persons.

A tuberculosis hospital is an institution which is primarily engaged in providing by or under the supervision of a physician, medical services for the diagnosis and treatment of tuberculosis.

To qualify as a psychiatric or tuberculosis hospital the institution must be accredited by the Joint Commission on Accreditation of Hospitals, have in effect a utilization review plan, and meet additional staffing and medical record requirements.

A distinct part of a psychiatric or tuberculosis institution may qualify as a psychiatric or tuberculosis hospital independently of the institution of which it is a part, if the part meets certain specified requirements.

**203.2 Hospital for Emergency Services.**—A nonparticipating hospital within the United States may receive payment for covered emergency inpatient hospital services and outpatient hospital diagnostic services if it meets the requirements in the definition of a hospital, except for the utilization review and health and safety requirements. Coverage continues only as long as the emergency continues.

Emergency inpatient hospital services outside the United States are covered under limited conditions arising ordinarily only in border areas.

## 205. PARTICIPATING PROVIDERS OF SERVICES

Providers of services are Hospitals, Extended Care Facilities, and Home Health Agencies.

Payment may ordinarily be made only to a **participating** provider for covered services furnished by the provider or by others under arrangements with the provider. A participating provider is an institution, facility, or agency which has been approved by the



Social Security Administration as a provider of services, and has entered into an agreement with the Administration which provides that it will not charge any patient or other person for covered items and services, for which an individual is entitled to have payment made under the program; will return any money incorrectly collected; and will provide services on a non-discriminatory basis in compliance with Title VI of the Civil Rights Act of 1964.

## 206. UNDER ARRANGEMENTS

A provider may make arrangements with others to furnish covered items or services. When such arrangements are made, receipt of payment by the provider for the services (whether it bills in its own right or on behalf of those furnishing the services) must relieve the beneficiary or any other person of further liability to pay for the services.

### Coverage of Services Under Hospital Insurance

## 210. REQUIREMENTS—GENERAL

Effective January 1, 1967, posthospital extended care services furnished to inpatients of an extended care facility are covered under the hospital insurance program. Patients having hospital insurance coverage are entitled to have payment made on their behalf for the reasonable cost of covered extended care services furnished by the facility, by others under arrangements with the facility, or by a hospital with which the facility has a transfer agreement in effect.

## 211. PRIOR HOSPITALIZATION AND TRANSFER REQUIREMENTS

In order to have payment made for posthospital extended care services, the individual must have been an inpatient of a hospital for at least 3 consecutive calendar days and have been transferred to an extended care facility within 14 days after discharge from the hospital.

**211.1 Three-Day Prior Hospitalization.**—The hospital discharge must occur after June 30, 1966, or on or after the first day of the month in which the individual attains age 65, whichever is later. In de-

termining whether the required 3-day period of hospitalization has been met, the day of admission, **but not the day of discharge**, is counted as a hospital inpatient day.

The hospital need not be one with which the extended care facility has a transfer agreement; but must at least be one which meets all of the requirements in the definition of hospital, except the utilization review and health and safety requirements.

To be covered, the extended care services must have been necessitated by a condition which occasioned the patient's qualifying hospital stay, or by a condition which arose while in the facility for treatment of a condition for which he was previously hospitalized.

**211.2 Fourteen-Day Transfer.**—In determining the 14-day period, the day of discharge from the hospital is not counted in the 14 days. For example, a patient discharged from a hospital on August 1, and admitted to an extended care facility on August 15 was admitted within 14 days.

If the individual leaves the extended care facility and is readmitted to the same, or any other qualified extended care facility (see § 201) within 14 days, he is deemed not to have been discharged from an extended care facility for purposes of this requirement. Thus, the period of extended care services may be interrupted briefly and then resumed, if necessary, without hospitalization preceding the readmission to a qualified facility.

Hospitalization within the 14-day period after discharge from an extended care facility may also be treated as a return to an extended care facility within the 14-day period. For example, a person suffers a relapse which requires a resumption of skilled nursing care within 14 days after he is discharged from an extended care facility. Because there is no bed available in an extended care facility, he is placed in a hospital for less than 3 days and is then placed in a qualified extended care facility. Under these conditions, the person would be considered as having returned to an extended care facility within the 14-day period, even if the second admission to the extended care facility occurs more than 14 days after his first discharge from such a facility.

**211.3 Requirements Applicable to Extended Care Facility Inpatients on January 1, 1967.**—A hospital insurance beneficiary who is an inpatient of an extended care facility prior to January 1, 1967, the *effective* date of extended care coverage, is entitled to have payment made for extended care services beginning January 1, 1967, providing (1) he is on that date an inpatient of an institution which becomes a participating provider as of that date (see § 211.4 below for provisions applicable when the effective date of the facility's agreement is subsequent to January 1, 1967), and (2) he was transferred to that facility within 14 days of his discharge from a hospital of which he was an inpatient for 3 consecutive calendar days, and (3) he was discharged from the hospital after June 30, 1966, or on or after the first day of the month in which he became age 65, whichever is later, and (4) he has not been out of a facility for more than a 14-day period (§ 211.2 above).

**211.4 Institutions Deemed Extended Care Facilities as of July 1, 1966, for Purposes of the 14-Day Requirement.**—For purposes of the 14-day requirement, an institution will be deemed to be an extended care facility as of July 1, 1966, if the effective date of its agreement is January 1, 1967. An institution having an agreement which has an effective date later than January 1, 1967, but prior to February 1, 1967, will also be deemed an extended care facility as of July 1, 1966, providing its application for participation in the program was filed prior to December 17, 1966. An institution which filed an application for participation in the program before December 17, 1966, but subsequently withdrew its application will also be deemed to be an extended care facility as of July 1, 1966, but only if it filed a request for reinstatement of its application for participation before January 1, 1967, and has an agreement with an effective date prior to February 1, 1967. An institution which filed for participation after December 16, and has an agreement that is effective later than January 1, 1967, cannot be deemed to be an extended care facility as of July 1, 1966. It would be considered an extended care facility only as of the date of its agreement. The date of filing an application for participation in the program for this purpose is the date on which it is received in the State agency.

The following examples illustrate the application of the 14-day requirement as it applies to the above institutions:

**Example 1:** John, following a qualifying hospital stay ending on August 15, 1966, is admitted within 14 days to an institution which is deemed to be an extended care facility as of July 1, 1966. He remains an inpatient of that institution until March 31, 1967, when he is discharged. The effective date of the institution's agreement is January 15, 1967. John would be entitled to posthospital extended care benefits starting January 15.

**Example 2:** David, following a qualifying hospital stay ending on August 15, 1966, is admitted on August 19, 1966, to an institution which is *not* deemed to be an extended care facility as of July 1, 1966. He remains an inpatient of this institution until September 30, 1966, when he is discharged. On October 2 he is admitted to an institution which is deemed to be an extended care facility as of July 1, 1966, and is still an inpatient of the institution on January 15, 1967, the effective date of the institution's agreement. David is not eligible for extended care benefits since he did not, within 14 days of his qualifying hospital stay, enter an institution deemed to be an extended care facility as of July 1, 1966. If the first institution had been one which is also deemed to have been an extended care facility as of July 1, 1966, David would be entitled to benefits as of the effective date of the second institution's agreement.

**Example 3:** On September 30, 1966, within 14 days of a qualifying hospital stay, Sue entered an institution which is deemed to be an extended care facility as of July 1, 1966, its agreement being effective January 30, 1967. She is discharged from the institution on January 25, 1967. On February 7, 1967, she is admitted to another extended care facility having an agreement effective February 4, 1967. Since Sue is not considered to have been discharged from the extended care facility (§ 211.2), she would be entitled to benefits beginning February 7, 1967.

**Example 4:** Institution A's participation agreement is effective February 10, 1967. Doug, who was discharged from a qualifying hospital stay on January 25, is admitted to Institution A on February 1, 1967. Since Institution A does not meet the requirements for being deemed an extended care facility as of July 1, 1966, the earliest date it can be considered an extended care facility is February 10, 1967, the effective date of its agreement. Therefore, although Doug entered Institution A within 14 days of a qualifying hospital stay, he is not entitled to benefits since the institution was not an "extended care facility" until after the 14-day period involved had expired.



## 212. COVERED EXTENDED CARE SERVICES

Patients covered under hospital insurance are entitled to have payment made on their behalf on a reasonable cost basis for covered extended care services. If a patient receives items or services in excess of, or more expensive than those for which payment can be made, payment will be made only for the reasonable cost of the covered items or services. If the items or services were requested by the patient, the facility may charge him the difference between the amount customarily charged for the services requested and the amount customarily charged for covered services.

An **inpatient** is a person who has been admitted to an extended care facility for bed occupancy for purposes of receiving inpatient services. A person is considered an inpatient if formally admitted as an inpatient with the expectation that he will remain at least over night and occupy a bed even though it later develops that he can be discharged and does not actually use a bed over night.

**Note: Custodial care (see § 240.9) is not covered extended care service.**

The following extended care services are covered under hospital insurance:

### 212.1 Nursing Care Provided by or Under the Supervision of a Registered Professional Nurse.—

**Note: The services of a private-duty nurse or other private-duty attendant are not covered.**

Private-duty nurses or private-duty attendants are registered professional nurses, licensed practical nurses, or any other trained attendant whose services are restricted to a particular patient by arrangement between the patient and the private-duty nurse or attendant.

**212.2 Bed and Board in Semiprivate Accommodations.**—Hospital insurance will pay for the reasonable cost of semiprivate accommodations (two, three, or four-bed accommodations) in connection with nursing care. When accommodations other than semiprivate are furnished, the following rules will govern.

**A. Private Rooms Medically Necessary.**—Payment may be made for the reasonable cost of a private room or other accommodations more expensive than semiprivate only when such accommodations are medically necessary. Private rooms will be considered medically necessary when the patient's condition requires him to be isolated for his own health or that of others.

The term isolation may apply when treating a number of physical and mental conditions. These include communicable diseases which require isolation of the

patient for certain periods. Privacy may also be necessary for patients whose symptoms or treatment are likely to alarm or disturb others in the same room.

**B. Private Rooms Not Medically Necessary.**—When accommodations more expensive than semiprivate are furnished the patient because, at the time of admission, less expensive accommodations are not available, the program may pay only the reasonable cost of semiprivate accommodations.

When accommodations more expensive than semiprivate are furnished the patient **at his request** in the absence of medical necessity, the facility may charge the patient no more than the difference between the customary charges for the accommodations furnished and the customary charges for semiprivate accommodations at the most prevalent rate at the time of admission. No such charge may be made to the patient unless he requested the more expensive accommodations. (See D. below for a definition of "customary charges" and "most prevalent rate.")

**C. Wards.**—When accommodations less expensive than semiprivate are furnished **at the patient's request or for a reason determined to be consistent with the purposes of the health insurance program**, payment may be made for the reasonable cost of the accommodations furnished. It is considered to be consistent with the program's purposes to furnish bed and board in less expensive accommodations where semiprivate accommodations are not available. However, the patient must be moved to semiprivate accommodations when they become available. (Payment to extended care facilities which have **only** ward accommodations will be made on the basis of the reasonable cost of the accommodations furnished.)

In some cases, a patient may be placed in accommodations less expensive than semiprivate **neither at his request nor for a reason consistent with the program's purposes**. It is not consistent with the purposes of the law to assign a patient ward accommodations on the basis of his social or economic status, his national origin, race, or religion, or his entitlement to benefits as a medicare patient, or any other discriminatory reason, when the patient has not requested such assignment. An extended care facility which repeatedly assigns patients to accommodations less expensive than semiprivate neither at the patient's request nor for reasons consistent with the purposes of the program will be subject to termination of its participation agreement.

When ward accommodations are furnished neither at the patient's request nor for a reason consistent with





the program's purpose, reimbursement will be made at a reduced rate. The payment to be made shall be the reasonable cost of semiprivate accommodations minus the difference between the institution's customary charges for semiprivate accommodations at the most prevalent rate (see D. below) at the time of the patient's admission and the charge customarily made for the accommodations furnished the patient by the institution. (For example, the reasonable cost of semiprivate accommodations is \$15 per day. The most prevalent customary charge rate for a semiprivate room was \$17 per day and \$10 per day the customary charge for ward accommodations. The extended care facility would be paid \$8 per day for the ward accommodations, i.e., \$17 minus \$10 equals \$7; \$15 minus \$7 equals \$8.) However, payment will not be made for more than the reasonable cost of ward accommodations regardless of the amount indicated by the use of this formula. The reduction in payment, when appropriate, will be made at the end-of-year settlement.

**D. Customary charges** means amounts which the extended care facility is uniformly charging patients currently for specific services and accommodations. The **most prevalent rate** for semiprivate accommodations is the rate which applies to the greatest number of semiprivate beds.

### **212.3 Physical, Occupational and Speech Therapy Furnished by the Extended Care Facility or by Others Under Arrangements Made by the Facility.—**

**A. Physical therapy** includes assistance to the physician in evaluating patients by applying diagnostic and prognostic muscle, nerve, joint, and functional ability tests, and treating patients to relieve pain, develop or restore function, and maintain maximum performance, using physical means such as exercise, massage, heat, water, light, and electricity.

A qualified physical therapist is licensed or registered by the State when licensure laws are applicable, and meets the following criteria:

1. Graduation from a physical therapy curriculum approved by the American Physical Therapy Association from 1928 to 1936, or by the Council on Medical Education and Hospitals of the American Medical Association from 1936 to 1960, or by the Council on Medical Education of the American Medical Association in collaboration with the American Physical Therapy Association since 1960; or

2. Membership in the American Physical Therapy Association or registration by the American Registry of Physical Therapists; or

3. If the physical therapist was trained outside the United States:

- a. Graduation since 1928 from a physical therapy curriculum approved in the country in which the curriculum was located, and the curriculum must have been in a country in which there is a member organization of the World Confederation for Physical Therapy; and

- b. Membership in a member organization of the World Confederation for Physical Therapy; and

- c. Completion of 1 year's experience under the supervision of an active member of the American Physical Therapy Association; and

- d. Successful completion of a qualifying examination as prescribed by the American Physical Therapy Association.

An individual who graduated from any school before its physical therapy curriculum was approved by the appropriate organization mentioned in 1. above is not a qualified physical therapist unless, of course, he is a member of the American Physical Therapy Association or is registered by the American Registry of Physical Therapists.

**B. Speech therapy** includes assistance to the physician in evaluating patients to determine the type of speech or language disorder and the appropriate corrective therapy; providing rehabilitative services for speech and language disorders.

A speech therapist is certified by the American Speech and Hearing Association, or has completed the academic requirements and is in the process of accumulating the necessary supervised work experience required for certification.

**C. Occupational therapy** includes assistance to the physician in evaluating the patient's level of function by applying diagnostic and prognostic tests; guiding the patient in his use of therapeutic creative and self-care activities for improving function.

An occupational therapist is registered by the American Occupational Therapy Association or is a graduate of a program approved by the Council on Medical Education of the American Medical Association in collaboration with the American Occupational Therapy Association and is in the process of accumulating supervised clinical experience required for registration.

An occupational therapy assistant is one who works under the supervision of a qualified occupational therapist and has successfully completed a training course approved by the American Occupational Therapy Association, and is certified by that body as a certified occupational therapy assistant.

**212.4 Medical Social Services To Meet the Patient's Medically Related Social Needs.**—Medical social services include, but are not limited to, (a) assessment of the social and emotional factors related to the patient's illness, his need for care, his response to treatment, and his adjustment to care in the facility; (b) appropriate action to obtain case work services to assist in resolving problems in these areas; (c) assessment of the patient's medical and nursing requirements, his home situation, his financial resources, and the community resources available to him in making the decision regarding his discharge; (d) arrangements for referral to the appropriate agency where a need for financial assistance is indicated.

**212.5 Drugs and Biologicals.**—Drugs and biologicals for use in the facility which are ordinarily furnished by the facility for the care and treatment of inpatients are covered.

Two basic requirements must be met in order for a drug or biological furnished by a facility to be included as a covered extended care service. The drug or biological must (1) represent a cost to the institution in rendering services to the beneficiary; and (2) the drug or biological must either be included, or approved for inclusion, in the U.S. Pharmacopoeia, the National Formulary, the U.S. Homeopathic Pharmacopoeia, or New Drugs or Accepted Dental Remedies (except for those unfavorably evaluated).

**A. Drugs Included in the Drug Compendia.**—Coverage is provided only for those drugs and biologicals included, or approved for inclusion, in the latest official editions of the compendia. The latest official editions or revisions are: (1) U.S. Pharmacopoeia, 17th Revision, official from September 1, 1965, (2) the National Formulary, 12th Edition, official from September 1, 1965, (3) U.S. Homeopathic Pharmacopoeia, 7th Revised Edition, 1964, (4) New Drugs, 1966, and (5) Accepted Dental Remedies, 1966.

The exclusion from coverage of drugs and biologicals unfavorably evaluated in New Drugs and Accepted Dental Remedies applies to those drugs and biologicals which have been unfavorably evaluated for **all** medicinal uses. If a drug or biological has been unfavorably evaluated for one or more, **but not all**, medicinal uses, the exclusion applies only where the drug has been unfavorably evaluated for the medicinal use to which it is being put.

Drugs and biologicals are considered "approved for inclusion" in a compendium if approved under the established procedure by the professional organization responsible for revision of the compendium.

**B. Drugs Not Included in the Compendia.**—

Drugs not included, or approved for inclusion, in the drug compendia are nevertheless covered if such drug (1) was furnished the patient during his prior hospitalization, (2) was approved for use in the hospital by the hospital's pharmacy and drug therapeutics (or equivalent) committee; and (3) is required for the continuing treatment of the patient in the extended care facility.

**C. Combination Drugs.**—Combination drugs are covered if the combination itself or all the therapeutic ingredients of the combination are included, or approved for inclusion, in any of the designated drug compendia. Under the limited circumstances mentioned in B. above, a combination drug approved by a hospital pharmacy and drug therapeutics committee may also be covered as an extended care service.

**D. Drugs Specially Ordered for Inpatients.**—Covered drugs and biologicals are not limited to those routinely stocked by the extended care facility. A drug or biological not stocked by the facility but which the facility obtains for the patient from an outside source, such as a pharmacy in the community, is covered, if it represents a cost to the facility; that is, the facility rather than the patient is responsible for making payment to the supplier. Whether a drug or biological is covered under such circumstances depends upon the financial arrangements with respect to the individual transaction. It is not required that the same practice be followed by the facility for all patients in obtaining drugs from an outside source. For example, the fact that public assistance payments for drugs furnished to a welfare patient are made to the pharmacy in the community, rather than the facility (which in this case does not incur a cost for the drug), does not preclude coverage of the same drugs when purchased directly by the facility for the use of other patients.

**E. Drugs for Use Outside the Facility.**—Drugs and biologicals furnished by a facility to an inpatient for use outside the facility are, in general, not covered as extended care services. However, if the drug or biological is deemed medically necessary to permit or facilitate the patient's departure from the facility, and a supply is required until he can obtain a continuing supply, the drugs or biologicals would be covered as an extended care service. Drugs and biologicals furnished to outpatients of extended care facilities are not covered.

**212.6 Supplies, Appliances, and Equipment.**—Supplies, appliances, and equipment furnished for use in the facility, which are ordinarily furnished by the facility for the care and treatment of inpatients are covered extended care services. However, under cer-



tain circumstances, supplies, appliances, and equipment used during the beneficiary's stay are covered even though they leave the facility with the patient when he is discharged. These are circumstances in which it would be unreasonable or impossible from a medical standpoint to limit the patient's use of the item to the periods during which the individual is an inpatient. An example of items covered under this rule is a brace temporarily attached to the patient's body while he is receiving treatment as an inpatient and which is also necessary to permit or facilitate the patient's release from the facility.

Supplies, appliances, and equipment furnished to a patient for use **only** outside the facility would not, in general, be covered as extended care services. However, a temporary or disposable item provided to a patient which is medically necessary to permit or facilitate his departure from the facility and is required until such time as he can obtain a continuing supply would be covered as an extended care service.

**212.7 Medical Services of an Intern or Resident-in-Training.**—The medical services of an intern or resident-in-training under an approved teaching program of a hospital with which the facility has in effect the required transfer agreement are covered under hospital insurance.

An "approved teaching program" means a program approved by the Council on Medical Education of the American Medical Association or, in the case of an osteopathic hospital, approved by the Committee on Hospitals of the Bureau of Professional Education of the American Osteopathic Association. In the case of services of an intern or resident-in-training in the field of dentistry in a hospital or osteopathic hospital, the teaching program must have the approval of the Council on Dental Education of the American Dental Association.

The medical and surgical services furnished to the facility's patients by interns and residents-in-training of a hospital with which the facility has a transfer agreement are covered under medical insurance if the services are not covered under hospital insurance.

The services performed by interns and residents—including a physician acting in the capacity of an intern or resident—are reimbursable to the facility on a reasonable cost basis even though the intern or resident is a licensed physician. These services are not reimbursable on a reasonable charge basis as physicians' services.

**212.8 Other Diagnostic or Therapeutic Services Provided by a Hospital.**—Extended care services also include other diagnostic or therapeutic serv-

ices provided by a hospital with which the facility has a transfer agreement.

**212.9 Other Services.**—Other services which are necessary to the health of the patients are covered if the services are the type generally provided by extended care facilities. For example, the use of an operating room would not be covered since operating rooms are not generally maintained as part of such facilities. Items or services that would not be included as inpatient hospital services if furnished to an inpatient of a hospital are also excluded from extended care coverage. See § 110.2 for summary of inpatient hospital services.

## Services Covered Under Medical Insurance

### 213. AMBULANCE SERVICE

An ambulance is a specially designed or equipped automobile or other vehicle (in some areas of the United States this might be a boat or plane) for transporting the sick or injured. It must have customary patient care equipment such as a stretcher, clean linens, first aid supplies, oxygen equipment, and it must also have such other safety and lifesaving equipment as is required by State or local authorities. Personnel whose duties involve the care or handling of the patient while providing ambulance service must have adequate training in the application of first aid, i.e., training which is at least equivalent to the training provided by the standard and advanced Red Cross first aid courses. The driver would not have to meet the first aid training requirement if there is at least one other person assigned to the ambulance who has had the required training. Training "equivalent" to the standard and advanced Red Cross first aid training courses includes ambulance service training and experience acquired in military service, successful completion by the individual of a comparable first aid course furnished by or under the sponsorship of State or local authorities, an educational institution, a fire department, a hospital, a professional organization, or other such qualified organization. On-the-job training involving the administration of first aid under the supervision of or in conjunction with trained first aid personnel for a period of time sufficient to assure the trainee's proficiency in handling the wide range of patient care services that may have to be performed by a qualified attendant can also be considered as "equivalent training."

**A. For coverage of ambulance services** each of the following three conditions must be met:

1. The vehicle utilized to provide the ambulance service and the ambulance personnel whose duties in-

volve care of the individual to be transported by the ambulance meet the requirements specified above;

2. Ambulance service is covered only where the use of any other method of transportation is medically contraindicated by the patient's conditions. (In any case in which some means of transportation other than an ambulance could be utilized without endangering the individual's health, whether or not such other transportation is actually available, no payment may be made for ambulance service.)

3. The patient must have been transported to the nearest hospital with appropriate facilities or to one in the same locality, and under similar restrictions, from one hospital to another, or to an extended care facility. The patient may, likewise, be transported from one of these institutions to his home (or place of residence) if such home is within the locality of the institution.

The requirement that a patient be transported to the **nearest hospital with appropriate facilities** or to one in the **same locality** as that hospital (and under similar restrictions from one hospital to another, to the patient's home, or to an extended care facility) is intended to provide coverage of essential ambulance service, without imposing an arbitrary "mileage" limitation. It is not contemplated, however, that payment would be made for ambulance services that involve transporting the patient beyond the locality even if the patient is transported to a participating hospital or extended care facility. The term **locality**, with respect to ambulance service, means the service area in the geographic territory surrounding the institution from which individuals normally come or are expected to come for medical services.

The term **appropriate facilities** means that the institution has available the services, supplies, and staff necessary to provide the medical care called for by the patient's injury or illness. The fact that a more distant institution is better equipped, either qualitatively or quantitatively, to care for the patient does not warrant a finding that a closer institution does not have "appropriate facilities." However, a patient need not necessarily be taken to the nearest hospital or facility with appropriate facilities; he can be taken to another hospital or facility in the same locality.

**B. If an ambulance is operated by an extended care facility**, reimbursement for this service is made under the supplementary medical insurance program on a reasonable cost basis. The cost of oxygen administered in connection with ambulance service is also covered. See § 252.1 for required physician certi-

cation for coverage of extended care facility furnished ambulance service.

## **Facility-Based Physicians**

### **215. FACILITY-BASED PHYSICIANS' SERVICES**

The medical insurance program covers the reasonable charges for physicians' services rendered to individual beneficiaries. The charges of facility-based physicians (e.g., those on salary) for services directed to the medical care of the individual patient must be specially billed either by the physician or by the facility on his behalf. However billed, reimbursement is made for medical services to individual patients on a reasonable charge basis by the supplementary medical insurance (Part B) intermediary. (See § 404 for billing by the facility for these services.)

Facility-based physicians often perform services other than those clearly directed to the medical care of individual patients. These may involve teaching and administrative services, and other services that benefit the facility's patients as a group. Such physician services, not directly related to an individual patient, if compensated, must be considered in computing reimbursable facility costs and, as such, will be reflected in amounts payable to the facility under Part A for services rendered program beneficiaries.

Detailed information on reasonable cost and charge computation is contained in "Principles of Reimbursement for Provider Costs and for Services by Hospital-Based Physicians." These principles establish the criteria for distinguishing between the services of facility-based physicians which are reimbursable as provider services and those services reimbursable as physicians' services to patients. The principles also establish a basis for determining the reasonable charges for physicians' services to patients where, under the existing arrangement between the facility and the physician, billings to patients have not separately identified charges for physicians' services to patients. Where charges for physicians' services to patients have been identified separately, the customary charges for physicians' services have been established and afford a basis for determining the reasonable charges for such services. Finally, the principles establish a basis for ascertaining the customary charges for a physician's services to patients where, under a previous arrangement between the facility and the physician, charges to patients were not separately identified, but this arrangement is modified and the facility and the physician agree to bill patients separately for their respective services.



The extended care facility's Part A intermediary will obtain from the facility information it and the Part B carrier need to make payment determinations where the services of facility-based physicians are involved. The Part A intermediary has the responsibility for reviewing and approving the reasonableness of the agreement between facility and physician on the allocation of physician compensation (received from or through the facility) between (1) the portion attributable to provider services, i.e., services to the institution and (2) the portion attributable to physician services, i.e., identifiable services rendered by the physician to individual patients. If the facility and physician fail to agree or if their agreement appears unreasonable, the Part A intermediary and the Part B carrier will jointly assist in resolving the issue. The Part B carrier is responsible for review and approval, in accordance with the applicable principles, of the basis for Part B charges for services of facility-based physicians, i.e., the schedule of such charges if the item-by-item method of determination is used, or the uniform percentage if the optional method of determination is used.

### **Duration of Covered Extended Care Services**

#### **220. SPELL OF ILLNESS DEFINED**

A spell of illness is a period of consecutive days that **begins** with the first day (not included in a previous spell of illness) on which a patient is furnished inpatient hospital or extended care services by a qualified provider in a month for which the patient is entitled to hospital insurance benefits. A qualified hospital (including a psychiatric or tuberculosis hospital) or extended care facility is one that has been certified as meeting all the requirements of the definition of such an institution. A hospital which meets the requirements in § 203.2 is a qualified hospital for purposes of beginning a spell of illness when it furnishes the patient covered inpatient emergency services.

**Generally, the spell of illness begins when covered inpatient services are initially furnished to an entitled individual.**

However, admission to a qualified extended care facility will begin a spell of illness even though payment for the services cannot be made because the prior hospitalization or transfer requirement has not been met. (See § 211.)

The spell of illness *ends* with the close of a period of 60 consecutive days during which the patient was neither an inpatient of a hospital nor an inpatient of an extended care facility. To determine the 60 consecutive day period, begin counting with the day **following**

the day on which the individual was discharged. **It is important to note that for purposes of continuing a spell of illness the hospital or extended care facility in which the stay occurs need not meet all of the requirements that are necessary for starting a spell of illness.**

Inpatient services will prolong the beneficiary's spell of illness if the hospital meets the initial requirement of the definitions in §§ 203 and 203.1. That is, it is primarily engaged in providing, by or under the supervision of physician(s), to inpatients (1) diagnostic and therapeutic services for medical diagnosis, treatment, and care of injured, disabled, or sick persons, or rehabilitation services for injured, disabled, or sick persons; or (2) psychiatric services for the diagnosis and treatment of mentally ill persons; or (3) medical services for the diagnosis and treatment of tuberculosis.

Similarly, inpatient services in an **extended care facility** will prolong a beneficiary's spell of illness if the facility (including one primarily for the care and treatment of mental diseases or tuberculosis) meets at least requirement 201.a of the definition. That is, it is primarily engaged in providing to inpatients skilled nursing care and related services for patients who require medical or nursing care, or rehabilitation services for injured, disabled, or sick persons.

An individual may be discharged from and readmitted to a hospital or extended care facility several times during a spell of illness and still be in the same spell if 60 days have not elapsed between discharge and readmission. Inpatient stays during the same spell of illness need not be for the same or related physical or mental conditions. (For necessary relationship of extended care facility patient's condition to prior hospitalization, see § 211.)

As long as a person continues to be entitled to hospital insurance, there is no limit to the number of spells of illness he may have.

**Example 1:** X was born August 9, 1902. On July 28, 1967, X entered a participating general hospital. After he had been in the hospital for 2 weeks X was discharged on August 11, 1967. On his doctor's orders X entered a participating extended care facility on August 15, 1967, and remained there until his discharge on October 27, 1967. He had no further inpatient stays in 1967. X's spell of illness began on August 1, 1967, the first day of the month he attained age 65 and was entitled to hospital insurance. The spell of illness ended December 26, 1967, 60 days after his last discharge.

**Example 2:** Y, over age 65, entered a participating general hospital on July 28, 1968, for treatment



of a heart condition. He was discharged on August 11, 1968. On August 20, 1968, Y entered a *nonparticipating nursing home*, which provided primarily skilled nursing care and related services. Y remained in this facility until his discharge on October 27, 1968. On December 25, 1968, Y was again admitted to a participating hospital because of injuries suffered in an accident. He was discharged on January 13, 1969, and had no further inpatient stays in 1969. Y's spell of illness began on July 28, 1968: His stay in the nursing home began less than 60 days after his hospital discharge and the spell was continued even though the stay was not covered. The subsequent hospital stay began less than 60 days after the nursing home discharge and continued the spell of illness, although the condition treated was unrelated to his prior stays. The spell ended on March 14, 1969.

**Example 3:** Z, over age 65 and entitled to hospital insurance benefits, was admitted to General Hospital on August 1, 1966, and discharged on August 10, 1966, having received nonemergency hospital services. General Hospital met all the requirements in the definition of a hospital except those concerning utilization review and health and safety. While General Hospital met the minimum requirements for a prior-stay hospital, Z's *spell of illness did not begin* with his admission to this hospital because (1) the hospital did not meet all of the requirements in the definition of a hospital; and (2) although the hospital satisfied the requirements for coverage of emergency services, Z did not receive emergency inpatient care. Z was admitted to Haven Convalescent Home on August 20, 1966, and remained an inpatient of the home until his discharge on March 1, 1967. He had no further inpatient stays in 1967. Haven Convalescent Home became a participating extended care facility on January 1, 1967. Z's spell of illness began January 1, 1967, the day Haven Convalescent Home was determined to be a qualified extended care facility and the services Z received on that date were covered extended care services. Z's spell of illness *ended* April 30, 1967, 60 days after his discharge from the convalescent home.

## 222. EXTENDED CARE BENEFIT DAYS

A patient having hospital insurance coverage is entitled to have payment made on his behalf for up to 100 days of covered inpatient extended care services in each spell of illness. (For coinsurance provision, see § 226.)

The number of days of care charged to a beneficiary for extended care services will always be in units of

full days. A day begins at midnight and ends 24 hours later. Facilities may use a different definition of day for statistical or other purposes, but in reporting days of care used by beneficiaries, the midnight-to-midnight method is to be used. With the exception of the day of discharge, a day on any part of which an individual is an inpatient is counted as an inpatient day. In counting inpatient days for reimbursement purposes and in determining the total number of days of inpatient care utilized by the beneficiary, the day of admission is counted, but the day of discharge is not counted. This recognizes that the day of admission and the day of discharge are partial days. If admission and discharge occur on the same day, the day is considered a day of admission and counts as 1 inpatient day.

## 224. SERVICES COUNTING TOWARD MAXIMUMS

Extended care services count toward the maximum number of benefit days payable per spell of illness only if:

- (1) Payment for the services is made, or
- (2) Payment for the services would be made if a request for payment were properly filed and if the physician certified that the services were medically necessary. Where payment cannot be made because of the extended care coinsurance requirement, the day(s) used in satisfying this requirement nevertheless count toward the beneficiary's maximum days of extended care.

## 226. COINSURANCE—EXTENDED CARE SERVICES

The beneficiary is responsible for a coinsurance amount, initially \$5, (one-eighth of the inpatient hospital deductible) for each day after the 20th and through the 100th day of extended care services furnished during a spell of illness.

## General Exclusions From Coverage

### 240. GENERAL EXCLUSIONS

No payment can be made under **either** the hospital insurance or supplementary medical insurance programs for the following items and services:

**240.1 Items and services which are not reasonable and necessary** for the diagnosis or treatment of illness or injury or to improve the functioning of a malformed body member are not covered. Potential personal comfort items and services such as massages and heat lamp treatments are not covered unless they

contribute meaningfully to the treatment of an illness or injury, or the functioning of a malformed body member.

**240.2 Items and Services for Which There is No Legal Obligation to Pay.**—Free services are excluded from coverage, e.g., free chest x-rays provided by health organizations.

This exclusion does not apply if the patient has a legal obligation to pay, or some other person or organization has a legal obligation to pay for or provide the items or services. Thus, benefits for covered items and services would be paid by the program even though the same services were covered by a prepayment plan or health insurance policy. Such a plan may pay money toward the cost of services or it may maintain its own facilities and professional supporting staff.

In applying this exclusion the determining factor is that there is no legal obligation to pay for the items or services, and not merely the fact that the patient is not charged because of other considerations. This exclusion, therefore, does not prohibit program payment for services rendered to:

A. **Members of religious orders** who are not charged because of a vow of poverty;

B. **Indigents** who because of their inability to pay are not charged by an institution which customarily charges for such services;

C. **The patient whose need for services resulted from the act or negligence of another** who is or may be legally liable for the patient's medical expenses. The existence of a third person's liability does not affect the patient's obligation to pay for the services he receives;

D. **Certain residents of homes for the aged.**—Coverage of health services furnished to a resident of a home for the aged depends on the agreement under which the services are provided.

1. The typical relationship between the **proprietary or profit-making home** and the residents is contractual. The home agrees to furnish or pay for certain services, including specified health services, in return for specified payments by the resident. Payment can be made under the health insurance program for the specified health services received by the resident of such a home since the home has a legal obligation to pay for or provide the services. Of course, payment may also be made for covered services not included in the resident's contract with the home, which he himself has a legal obligation to pay.

2. **Nonprofit homes** are generally operated by religious or fraternal organizations. The resident is ordinarily required to contribute to the cost of his maintenance

and health care to the extent that he is able. For example, the resident is usually required to assign to the home assets or income at the time of admission. Where this is the case, payment can be made under the program for covered services furnished the resident whether or not his circumstances permitted him to pay anything for his care.

However, where all services are furnished by the home on a purely charitable basis (i.e., no payment is accepted from residents regardless of their ability to pay), payment could not be made under the health insurance program for items and services furnished by the home. In this situation, however, payment could be made for services furnished by a source independent of the home if that source customarily charges for such services. Thus, payment could be made for services furnished by a hospital or extended care facility to which a resident of the home is sent, or for home health services furnished by an agency, or for the services of a physician who is not an employee of the home.

3. **Certain union homes** accept no payment from residents regardless of their ability to pay. Payment may, nevertheless, be made for services provided by such homes where admission to the home and access to the services is a matter of right for union members who meet the necessary qualifications.

4. **Homes for Members of Religious Orders.**—Many religious orders maintain homes similar to retirement homes to care for members who become ill or infirm. Since members of the order are under a vow of poverty, there is no charge made by the home for this care. The order is considered to have an obligation to care for its members who have rendered lifelong services. Payment may be made for services furnished in these homes, whether they are furnished by the home itself or by independent sources that customarily charge for their services.

**240.3 Items and services which are paid for by a governmental entity** other than under a title of the Social Security Act, such as a medical assistance program, or under a health benefits or insurance plan for employees of the governmental entity are not covered. The Secretary of Health, Education, and Welfare may specify other exceptions to this exclusion. The Secretary has approved payment for covered items and services even though provided free, if

A. furnished by participating State or local government-operated hospitals, including psychiatric and tuberculosis hospitals which serve the general community but not including hospitals which serve a special category of the population, e.g., prison hospitals, or



B. paid for by a State or local governmental entity and furnished an individual as a means to control infectious diseases or to provide for the medically indigent. These services need not be furnished in a hospital. Payment may be made for items and services furnished by a government-operated home for the indigent aged whether supplied directly by the home or purchased by it from independent physicians and hospitals. Payment may also be made for services furnished by a participating State-operated Veterans' Home and Hospital, provided the patient would, in the absence of program coverage, have been charged for the items and services, or he was admitted to the facility without charge as an indigent.

**240.4 Items and services which are not provided within the United States** are not covered (except for emergency inpatient hospital services furnished outside the United States under the conditions described in § 203.2 and payment on behalf of railroad beneficiaries for covered hospital insurance services furnished in Canadian hospitals). The United States includes the 50 States, the District of Columbia, the Commonwealth of Puerto Rico, the Virgin Islands, Guam, and American Samoa.

**240.5 Items and services which are required as a result of war**, or of an act of war, occurring after the effective date of the patient's current coverage are not covered.

**240.6 Personal Comfort Items.**—Items which do not contribute meaningfully to the treatment of an illness or injury or the functioning of a malformed body member are not covered.

**240.7 Routine physical checkups; eyeglasses and eye examinations** for the purpose of prescribing, fitting, or changing eyeglasses; **hearing aids and examinations for hearing aids**; and **immunizations** are not covered. Routine physical checkups include (a) examinations performed without relationship to treatment or diagnosis of a specific illness, symptom, complaint, or injury, and (b) examinations required by third parties such as insurance companies, business establishments, or Government agencies.

The exclusions apply to eyeglasses or contact lenses, and eye examinations for the purpose of prescribing, fitting, or changing eyeglasses or contact lenses for refractive errors. The exclusions do not apply to services performed in conjunction with an eye disease such as glaucoma or cataracts, or to postsurgical prosthetic lenses which are customarily used during convalescence from eye surgery in which the lens of the eye was removed, or to the permanent prosthetic lenses required

by an individual lacking the organic lens of the eye, whether by surgical removal or congenital absence. Such prosthetic lens is a replacement for an internal body organ—the lens of the eye.

Vaccinations or inoculations are excluded as “immunizations” unless they are directly related to the treatment of an injury or direct exposure such as anti-rabies treatment, tetanus antitoxin or booster vaccine, botulin antitoxin, antivenin sera, or immune globulin.

**240.8 Orthopedic Shoes or Other Supportive Devices for the Feet.**—The exclusion of orthopedic shoes does not apply to such a shoe if it is an integral part of a leg brace.

**240.9 Custodial Care.**—The custodial care exclusion precludes payment for that type of care, wherever furnished, which is designed essentially to assist the individual in meeting his activities of daily living—i.e., services which constitute personal care such as help in walking and getting in or out of bed, assistance in bathing, dressing, feeding, and using the toilet, preparation of special diets, and supervision over medication which can usually be self-administered—and which does not entail or require the continuing attention of trained medical or paramedical personnel.

**240.10 Cosmetic Surgery or Expenses Incurred in Connection with such Surgery.**—Cosmetic surgery includes any surgical procedure directed at improving appearance, except when required for the prompt (as soon as medically feasible) repair of accidental injury or for the improvement of the functioning of a malformed body member. For example, this exclusion does not apply to surgery in connection with treatment of severe burns or repair of the face following a serious automobile accident or surgery for therapeutic purposes, which coincidentally also serves some cosmetic purpose.

**240.11 Charges Imposed by Immediate Relatives of the Patient or Members of His Household** are not covered.—**Immediate relative** as used in this exclusion means spouse, father, mother, son, daughter, brother, or sister—by blood, marriage or adoption. **Members of the patient's household** means those persons sharing a common abode with the patient as part of a single family unit, including those related by blood or marriage as well as domestic employees and others who live together as part of a single family unit. A mere roomer or boarder is not included.

Where a business enterprise imposes the charge, and there is a question whether this exclusion applies, a determination must be made as to whether the firm in fact represents an individual within these relationships. If



an individual proprietorship is involved, the proprietor will be considered the individual imposing the charge. A corporation is a separate legal entity which cannot be a member of a household or an immediate relative. Charges imposed by a partnership do not fall within the exclusion unless all of the partners are within the designated relationships to the patient.

**240.12 Items and services in connection with the care, treatment, filling, removal, or replacement of teeth,** or structures directly supporting the teeth are not covered. Payment may be made, however, for (a) surgery related to the jaw or any structure contiguous to the jaw, or (b) the reduction of any fracture of the jaw or any facial bone, including dental splints or other appliances used for this purpose.

**240.13 Items and services** to the extent that payment has been made, or can reasonably be expected to be made **under a workmen's compensation law** or plan of the United States or a State may not be paid for by the program. Payments for items and services under the health insurance program are subject to repayment to the appropriate trust fund if notice or information is received that payment has been made for the items and services under a workmen's compensation plan. (See §§ 258ff.)

**240.14 Items or services which the provider is obligated** by a law of or because of a contract with the Federal Government **to render at public expense** are not covered.

**240.15 Items and services are not covered when furnished by a Federal provider** of services or other Federal agency except (a) for emergency inpatient hospital services and emergency outpatient hospital diagnostic services furnished by a Federal hospital meeting the requirements of § 203.2 or (b) when the Federal provider of services has been determined by the Secretary of Health, Education, and Welfare to be providing services to the public generally as a community institution or agency.

## Requirements for Payment

### 250. REQUEST FOR PAYMENT

Before payment can be made for extended care services or physicians' services billed through an extended care facility, a written request for payment signed by the patient or by another person qualified to do so on his behalf must be filed. The signature of the patient or other qualified person may be obtained on the respective billing forms, or, under specified conditions, the facility may obtain a single signature on its records.

**250.1 Billing Forms as Request for Payment.**—Each of the billing forms (Extended Care Admission and Billing, Form SSA-1478 and Provider Billing for Patient Services by Physicians, Form SSA-1554) contains a patient signature line incorporating the patient's request for payment of benefits, authorization to release information and assignment of benefits. When the billing form is used as the request for payment, the billing form must be signed. The request for payment will then be forwarded to the intermediary or to the Social Security Administration where the extended care facility deals directly with the Government, when the facility submits its bill.

A. The billing form as request for payment will be filed in connection with **each extended care facility admission**, even though multiple admissions may occur during the same spell of illness. Only one request for payment has to be filed, however, in connection with each inpatient admission, even though an extended stay occasions multiple billings.

B. Where the billing form is used as the request for payment for **physicians' services billed through the facility**, the signature of the patient is required with each billing by the facility.

**250.2 Request for Payment on Facility Record.**—In lieu of separate signatures on the billing forms, the facility may arrange with its hospital insurance intermediary to have the patient's signature on its admission records serve as the request for payment.

The pertinent language on the billing forms must be incorporated, by printing or stamp, either in the facility's own admission forms, or on a separate form attached to or associated with the facility's admission form. Where this procedure is adopted, "Patient's request for payment on file" should be stamped on the patient's signature line of the original of each billing form to indicate that the patient's statement is on file. When the facility has arranged with its hospital insurance intermediary to put this procedure into effect, the intermediary will make payment to the facility without the patient's signature on the billing form. The Part A intermediary will verify through its regular audit activities that the signatures are being obtained as specified. The medical insurance carrier will rely on the Part A intermediary's administration of this procedure and will make payment to a facility without the patient's signature on the form SSA-1554.

The following format is suggested for the statement on the facility's record:

### **"Statement to Permit Payment of Hospital and Medical Insurance Benefits to Extended Care Facilities"**

I certify that the information given by me in applying for payment under title XVIII of the Social Security Act is correct. I authorize release of any information needed to act on this request. I request that payment of authorized benefits be made in my behalf.

I assign payment for the unpaid charges of the physician(s) for whom the facility is authorized to bill in connection with its services. I understand I am responsible for any health insurance deductibles and 20 percent of the remaining reasonable charges."

Where the facility does not bill on behalf of its facility-based physicians, the assignment part of the above statement should be omitted. Where a patient does not want to assign the benefits for services of a facility-based physician, the assignment language should be lined out in that particular case.

**A. For extended care billing,** the patient's signature will cover only that particular stay regardless of its duration. When the patient is admitted for a new stay, another request for benefits is required.

**B. When facility-based physician services are billed** under this procedure, the patient's signature on the facility record will be effective for the duration of the particular facility stay. Thus, the patient's signature will cover all form SSA-1554's filed in connection with a single stay.

### **251. EXECUTION OF THE REQUEST FOR PAYMENT**

If at all practicable, the patient should sign the request whether on the billing form or on the facility's record at the time of admission. (See Admission Procedures, §§ 300ff.)

In certain circumstances, it would be impracticable for an individual to sign the request for payment himself because when he is admitted to the facility, he is unconscious, incompetent, in great pain, or otherwise in such a condition that he should not be asked to transact any business. In this situation, his representative payee (i.e., a person designated by the Social Security Administration to receive monthly benefits on the patient's behalf), a relative, legal guardian, or a representative of an institution (other than the facility) usually responsible for his care, or a representative of a governmental entity providing welfare assistance should, if present at time of admission, be asked and permitted to sign on his behalf.

When no request for payment is obtained at the time

of admission, the facility should attempt to obtain such a request later from the patient or other person described above. If the request cannot be so obtained by the time the facility would ordinarily submit its bill to the intermediary, an authorized official of the facility may sign the request.

When someone other than the patient signs the request for payment, the signer will submit a brief statement explaining his relationship to the patient and the circumstances which made it impracticable for the patient to sign. The facility will forward this statement with its billing, or retain it in its files if the signature is obtained on the facility's own record. The intermediary will generally accept such a statement as representing the true facts of the case in the absence of evidence to the contrary.

The extended care facility should not routinely sign the request on behalf of any patient. If experience reveals an unusual frequency of such facility-signed requests from a particular facility, the matter will be subject to review by the intermediary.

If a fully competent and capable patient **refuses** to sign the request for payment necessary for the facility to obtain reimbursement for the services it furnished, the facility may charge the patient or other person for the covered services.

### **252. CERTIFICATION AND RECERTIFICATION BY PHYSICIANS**

Payment for covered posthospital extended care services may be made only if a physician makes the required certification and, where services are furnished over a period of time, the required recertification regarding the services furnished.

**252.1 Certification.**—The certification must clearly indicate that posthospital extended care services were required to be given on an inpatient basis because of the individual's need for skilled nursing care on a continuing basis for any of the conditions for which he was receiving inpatient hospital services (or services which would constitute inpatient hospital services if the institution met the conditions of participation for hospitals except those relating to utilization review and health and safety requirements) prior to transfer to the extended care facility.

The certification must be signed by the admitting physician or by a physician on the staff of the extended care facility or the attending physician in case of an emergency, who has knowledge of the case. Certifica-



tions must be obtained at the time of admission, or as soon thereafter as is reasonable and practicable. However, the method by which certifications are obtained, and the format of the certification statement, is up to the individual extended care facility. The routine admission procedure followed by a physician would not be sufficient certification of the necessity for posthospital extended care services for purposes of the program.

If **ambulance service** is furnished by an extended care facility, an additional certification is required. It may be furnished by any physician who has sufficient knowledge of the patient's case including the physician who requested the ambulance or the physician who examines the patient upon his arrival at the facility. The physician must certify that the ambulance service was medically required.

**There is no requirement that certifications be entered on any specific form or handled in any specific way, so long as the approach adopted by the facility is such as to permit the intermediary to determine that the certification requirement is in fact met. The certification can, therefore, be entered or preprinted on a form the physician already has to sign, or a separate certification form can be used.**

**252.2 Recertifications.**—The recertification statement must meet the following standards as to its contents: it must contain an adequate written record of the reasons for continued inpatient services, the estimated period of time the patient will need to remain in the facility, and plans for home care. The extended care facility may, at its option, provide a special form for this purpose. The recertification statement made by the physician has to meet the content standards, unless, for example, all of the required information is in fact included in progress notes, in which case the physician's statement could indicate that the individual's medical record contains the required information and that continued posthospital extended care services are medically necessary. A statement reciting only that continued extended care services are medically necessary is not, in and of itself, sufficient.

If the circumstances require it, the first recertification and any subsequent recertifications must state that the continued need for extended care services is for a condition requiring such services which arose after the transfer from the hospital and while the patient was still in the facility for treatment of the condition(s) for which he had received inpatient hospital services.

The recertification must be signed by the attending physician, or by a physician on the staff of the extended

care facility or the physician who is available in case of an emergency who has knowledge of the case. The form of the written record and the manner of obtaining timely recertification is up to the individual facility.

**252.3 Timing of Recertifications.**—The first recertification must be made no later than as of the 14th day of inpatient extended care services. An extended care facility can, at its option, provide for the first recertification to be made earlier, or it can vary the timing of the first recertification within the 14-day period by diagnostic or clinical categories. Subsequent recertifications must be made at intervals not exceeding 30 days. Such recertifications may be made at shorter intervals as established by the utilization review committee and the extended care facility. Utilization review of a long-stay case would not serve as an alternative to subsequent recertifications. It is expected that utilization review committees serving extended care facilities will frequently not be a part of, or as closely associated with, the provider of services as will usually be the case with utilization review committees of hospitals. Thus, the purpose of the recertification requirement will best be served by requiring a physician who is associated with the case to be responsible for subsequent recertifications.

**252.4 Delayed Certifications and Recertifications.**—Extended care facilities are expected to obtain timely certification and recertification statements. However, delayed certifications and recertifications can be honored.

In addition to complying with the content requirement otherwise applicable, delayed certifications and recertifications must include an explanation for the delay and such medical or other evidence which the extended care facility considers relevant for purposes of explaining the delay. The format of delayed certification and recertification statements, and the method by which they are obtained, are up to the individual facility. A delayed certification and recertification can appear in one statement; separate signed statements for each certification and recertification are not required as they would be if timely certification and recertification had been made.

**252.5 Disposition of Certification and Recertification Statements.**—Extended care facilities do not have to transmit certification and recertification statements to the intermediary or the Administration; instead, the facility must itself certify, on the admission and billing form, that the required physician certification and recertification statements have been obtained and are on file.



Extended care facilities are required to commit to writing and keep on file the procedure they adopt with respect to the timing of recertifications—that is, the intervals at which recertifications are required. Failure to obtain the required certification and recertification statements in an individual case will result in the facility not being eligible to receive payment in that case.

**252.6 Certification and Recertification Requirement Where Individual Admitted to Facility Before January 1, 1967.**—In the case of individuals who become inpatients of an extended care facility prior to January 1, 1967, (when extended care benefits first become payable), the physician certification will not be required. Instead, recertifications must be provided as of the time they would be required if the patient had been admitted to the extended care facility on January 1, 1967. In these cases, the initial recertification must state that posthospital extended care services were required on an inpatient basis either because of a condition for which the individual was receiving inpatient hospital services prior to transfer to the extended care facility, or for a condition which arose after the transfer to such facility and while he was still in the facility for treatment of the condition or conditions for which he received inpatient hospital services.

## **Special Provisions Related to Payment**

### **255. REFUNDS**

In its agreement for participation the extended care facility has agreed not to charge for items or services for which an individual is entitled to have payment made on his behalf, and to make adequate provision for return (or other disposition) of any money incorrectly collected from an individual or any other person on his behalf (e.g., other insurance carriers or welfare).

**A. Money incorrectly collected** means amounts in excess of a deductible or coinsurance, if applicable, paid to a facility by an individual (or other person on his behalf) as payment for covered items and services for which the individual is entitled to have payment made under the health insurance program.

**B.** The cause of an incorrect collection may be a simple error on the part of a facility in billing a beneficiary for a covered item or service. An incorrect collection may also arise in a retroactive entitlement case, or workmen's compensation case, in which the beneficiary has paid for covered services to which he later becomes entitled under health insurance.

Where the intermediary knows that a facility has

overcollected the deductible and coinsurance amounts for Part B services, it will make direct refund to the beneficiary. (See § 402, Item 19.)

**255.1 Return or Other Disposition of Money Incorrectly Collected.**—A facility in possession of an incorrect collection is required to refund or set aside the money. An equivalent amount may be withheld from payments otherwise due the facility until the facility refunds or sets aside the money incorrectly collected.

**A. Making Refund.**—Refund is to be made to the beneficiary, or other person entitled to the refund. If the proper person cannot be located after reasonable effort by the facility (including an attempt at contact **by mail** at the last known address), the facility should request the intermediary to have the Administration's records examined in an effort to learn the individual's address. If the individual to whom the refund is to be made still cannot be located, the facility is to make disposition of the money in accordance with the law which would be applied by the courts of the State in which the facility is located.

**B. Money Set Aside.**—Where the beneficiary's whereabouts are unknown or where there is a delay in the appointment of a legal representative to dispose of the estate of a deceased individual, as well as in other cases in which it appears that refund will be delayed indefinitely, the facility will so notify the intermediary and will then set the funds aside in a separate account, identified by the name of the individual to whom the payment is due. These amounts will be carried on the facility's records in this manner until final disposition is made in accordance with the applicable State law.

**C. Appropriate Time Limits Within Which Facility's Action Must Be Taken.**—The incorrect collection should be refunded as promptly as possible. If refund cannot be made within 60 days after the date of the notice to the facility that an incorrect collection was made, the funds must be set aside as described in B. above.

### **258. WORKMEN'S COMPENSATION**

Payment under the Health Insurance for the Aged Act is excluded for any items and services to the extent that payment has been made or can reasonably be expected to be made under a workmen's compensation law or plan of the United States or a State. This exclusion is applicable to the workmen's compensation plans of the 50 States, the District of Columbia, and Puerto Rico, as well as the systems provided under the Federal Employees Compensation Act and the Longshoremen's and Harbor Workers' Compensation Act.

Health insurance payment for items or services is

conditioned on reimbursement to the trust fund when notice or other information is received that payment for an item or service has been made under workmen's compensation.

The individual is responsible for taking whatever action is necessary to obtain payment under workmen's compensation where such payment can reasonably be expected. His failure to take proper and timely action will preclude payment under the health insurance program to the extent that payments **could** have been made under workmen's compensation.

**258.1 Effect of Workmen's Compensation Payments on Eligibility and Spell of Illness.**—An individual's spell of illness will begin with the first day he receives inpatient services from a qualified hospital or extended care facility even though workmen's compensation coverage, rather than the health insurance program, pays, or may reasonably be expected to pay, for those services, if he is entitled to hospital insurance benefits in that month. However, where workmen's compensation pays the full cost of extended care services, extended care service days will not be charged against the patient's 100 days of extended care services in a spell of illness until the first day for which payment may be made under the hospital insurance program. Charging of days will not begin until workmen's compensation coverage expires, since payment can then be made under hospital insurance if the stay continues or there is a subsequent stay not covered by workmen's compensation.

**258.2 General Procedures in Workmen's Compensation Cases.**—When the facility is told that the patient's illness or injury is employment-related, this will be indicated on the billing form, and the employer's name and address given.

If the patient has already received a workmen's compensation payment for the current illness or injury (e.g., he was a patient in the facility before the current admission) the facility should furnish the intermediary any information available with the admission notice, since it is possible that a subsequent facility stay for the same condition may also be compensable under workmen's compensation. If there is a possibility of workmen's compensation coverage, the facility should file a claim with the workmen's compensation carrier.

Even though workmen's compensation payment has been or probably will be made, the facility should submit a bill for covered health insurance services to the intermediary or to the Social Security Administration if the facility deals directly with the Government.

**A. Workmen's Compensation Has Been or Is Being Paid.**—If at the time the patient's bill is sub-

mitted, workmen's compensation payment has been or is being made which fully covers the cost of the items and services furnished, no payment under the health insurance program may be made.

A lump sum compromise awarded as payment of a workmen's compensation claim may include an amount for medical, hospital, and posthospital expenses. The payment under health insurance in such cases is based on the intermediary's judgment as to what could reasonably have been expected to be paid for these services under workmen's compensation had the individual pursued his rights rather than accepting the amount of the compromise settlement.

The facility will be notified by the intermediary of the extent to which its bill was covered by workmen's compensation.

**B. Workmen's Compensation is Reasonably Expected.**—If, at the time the facility submits its bill, workmen's compensation has not been or is not being paid, the intermediary will determine whether workmen's compensation can reasonably be expected to pay for the items and services covered by the bill. Should the intermediary determine that there is a reasonable expectation that workmen's compensation payment will be made for the patient's care, the facility will be notified that health insurance payments may not be made due to the expectation of workmen's compensation coverage. The individual will also be notified of the intermediary's decision. In the event that workmen's compensation does not ultimately pay for the services, the claim under health insurance may be reopened.

**C. Workmen's Compensation is Questionable.**—Should the intermediary determine that workmen's compensation payments cannot reasonably be expected, payment under health insurance may be made to the facility on condition that such payment will be refunded in the event workmen's compensation later pays for the services. However, conditional payment will not be made unless there is a real question as to whether payment will be made by workmen's compensation. The mere fact that the employer or workmen's compensation carrier is contesting liability would not in itself be a sufficient basis to warrant conditional payment.

**258.3 Overpayments.**—If the facility receives workmen's compensation payments after having received health insurance payments for the same items and services, the program must be reimbursed for such overpayment. The facility may arrange with the intermediary to accomplish this by direct refund or adjustment of future program payments to the facility.



## 260. UTILIZATION REVIEW PLAN

A participating extended care facility is required to have in effect a plan for utilization review which applies to the inpatient services the facility furnishes to patients entitled to benefits under the health insurance program. The plan must provide for review on a sample or other basis, of admissions, duration of stays, and professional services furnished; and review of each case of continuous extended duration while the patient is in the facility. The detailed requirements for an acceptable utilization review plan are set out in § XVIII of the "Conditions of Participation for Extended Care Facilities" (HIM-3). Payments made to physicians serving on extended care facility utilization review committees will be considered as an allowable cost without regard to whether the facility's plan is applicable solely to medicare beneficiaries or to all patients of the facility.

**260.1 Definition of Extended Stay—Beneficiary Admitted Before January 1, 1967.**—The rules for the review of extended-stay cases are explained in § XVIII of the "Conditions of Participation for Extended Care Facilities" (HIM-3).

Generally, in determining when a case is subject to review as an extended stay case, the counting of days begins with the date of admission. However, a patient who is entitled to benefits as of January 1, 1967, i.e., is age 65 and has met the prior hospitalization and transfer requirements, is considered to have been admitted on January 1, 1967, if he is in a participating facility on that date.

**260.2 Further Inpatient Stay Not Medically Necessary.**—If in the review of an extended-stay case the physician members of the utilization review committee decide, after opportunity for consultation is given the attending physician, and after considering the availability and appropriateness of outside facilities and services, that further inpatient stay is not medically necessary, notification in writing of this decision must be given within 48 hours to the institution, the attending physician, and the patient. However, where the committee approves a request by the attending physician that he be permitted to notify the patient of the committee's decision, such notice will constitute proper notification to the patient. Payment cannot be made for more than 3 days of extended care services after the date the notice is received by the facility.

**260.3 Failure To Make Timely Review of Cases.**—If the Social Security Administration determines on the basis of information obtained by a State agency or by an intermediary during the course of its

ongoing review of utilization practices, that a facility has substantially failed to make timely review of long-stay cases, it may, in lieu of terminating its agreement with the facility, limit payment to the institution to no more than 20 consecutive days of extended care services furnished a beneficiary. This limitation would be applicable to beneficiaries admitted to the institution after an effective date specified in the written notice of the imposition of the restriction to be given to the facility, the public, and the hospital with which the facility has a transfer agreement.

The limitation will be removed when it is determined that timely review of long-stay cases has been restored and there is reasonable assurance that the deficiency will not recur.

## Appeals of Payment Determinations

### 270. EXTENDED CARE FACILITY PROTEST OF PAYMENT DETERMINATION

The extended care facility and its intermediary should attempt to resolve mutually any differences involving payment for services that arise from the application of the cost formula or the amount payable in a specific case. While no appeal is available for facilities or other providers from intermediary determinations involving payments, provider complaints and protests will be considered in Social Security Administration review of the intermediary's application of the cost formula or its compliance with the other terms of its agreement with the Government.

### 273. BENEFICIARY PROTESTS AND APPEALS OF PAYMENT DETERMINATIONS

**A. Hospital Insurance Program.**—An individual dissatisfied with any determination of the amount of benefits payable on his behalf under hospital insurance may have his claim reconsidered by the Social Security Administration. If he is not satisfied with the reconsideration determination and the amount in controversy is \$100 or more, he may request a hearing by the Social Security Administration. If the amount in controversy is \$1,000 or more and he is dissatisfied with the hearing decision, the individual may initiate action for Federal court review of the claim.

**B. Medical Insurance Program.**—An individual dissatisfied with denial of a request for payment of medical insurance benefits, or with the amount of medical insurance benefits paid, or with the promptness with which his request for payment is acted upon is entitled to an opportunity for a review by, and if still



dissatisfied, to a fair hearing by the medical insurance intermediary.

A patient dissatisfied with a payment for the services of a facility-based physician is entitled to a review by and, if still dissatisfied, to a fair hearing by the medical insurance intermediary to whom the bill for the physician's services was submitted for payment.

C. **Patient protests** concerning charges for items or services furnished by the extended care facility should be handled, if simply amenable to explanation

or correction, by the facility. If the patient wishes to protest the health insurance determination on his request for payment or the promptness of payment, he should be referred to his social security district office. The district office can offer assistance to the beneficiary in determining his appeal rights and can answer specific questions about the appeal procedures. The district office can also assist the individual in completing the necessary forms for requesting reconsideration or hearing.



### Chapter III

## ADMISSION PROCEDURES

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## Chapter III

### ADMISSION PROCEDURES

#### 300. SUMMARY OF ADMISSION PROCEDURES

Upon the admission of a medicare beneficiary, or as soon thereafter as practicable, the participating extended care facility should:

a. Obtain the patient's signed request for payment. (See §§ 250ff.)

b. Complete the admission notice (see §§ 303 and 303.1) and send the information to the intermediary, or to the social security district office if the facility deals directly with the Social Security Administration.

c. Obtain the physician's certification concerning the need for extended care services. (See §§ 252ff.)

In reply to the facility's admission notice, the intermediary will send a report of eligibility. This will show the patient's remaining days of eligibility and other data needed to complete the billing form. If the facility deals directly with the Social Security Administration, a Reply to the Notice of Admission (Form SSA-1568) will be sent from the Bureau of Health Insurance, Direct Reimbursement Branch, Baltimore, Maryland.

Detailed instructions for completing the admission notice are given in the following sections.

#### 301. 3-DAY HOSPITAL STAY AND 14-DAY TRANSFER REQUIREMENTS

As explained in § 211, a beneficiary must meet the prior hospital stay and transfer requirements to have extended care facility benefits paid on his behalf. The intermediary will determine at the time it forwards the report of eligibility to the extended care facility whether these requirements are met. The intermediary will rely on the information given in items 5, 9, and 11 of the Extended Care Admission and Billing (Form SSA-1478), whenever possible.

The prior-stay hospital will usually send a patient transfer form to the extended care facility, in accordance with their transfer agreement. When the facility has in its files a transfer form showing the hospital admission and discharge dates, or a written record of a telephone conversation with the transferring hospital in which this information was given, it should record

these dates in item 5 of the form SSA-1478. Otherwise, this item should be left blank to alert the intermediary to take necessary action to verify the prior-stay information.

In item 9 of the form SSA-1478, the facility should enter the actual date of admission to the facility, even though this was before January 1, 1967. Extended care facility benefits may be payable on behalf of beneficiaries effective January 1, 1967, even though they were admitted to the facility before that date. (See § 211.3.) Full details concerning the prior hospital stay dates and extended care facility stay or stays after June 30, 1966, and prior to January 1, 1967, should be given, so that the intermediary can determine whether the 3-day stay and 14-day transfer requirements were met. If additional space is required, attach a statement to the admission notice.

In item 11, the first entry should be the name and address of the 3-day prior stay hospital. If an intervening extended care facility stay or stays, or an intervening hospital stay of less than 3 days, occurred between the hospital discharge and the current extended care facility admission, the names and addresses of such intervening facilities or hospitals, participating or non-participating, should also be entered in item 11, or on a statement attached to the admission notice. (See § 303.2.)

#### 302. OBTAINING THE HEALTH INSURANCE CLAIM NUMBER

It is very important that the patient's health insurance claim number be accurately recorded on the admission and billing forms because the case cannot be processed if this number is missing or incorrect.

The Social Security Administration maintains in Baltimore, Maryland, the records of all persons entitled to health insurance. After entitlement is established, each beneficiary is issued a health insurance card by the central office of the Social Security Administration (or in some cases by the Railroad Retirement Board) for use in obtaining hospital insurance benefits, medical insurance benefits, or both. The health insurance claim number on the card is essential for locating the patient's

record when a claim for benefit payment is made. **No admission notice or billing form should be forwarded without the correct claim number.** Exhibit 1 of this chapter shows the health insurance cards and briefly explains the numbering system as an aid in recognizing valid numbers.

Usually, the patient's health insurance claim number will be shown on the hospital transfer form. If it is not, the facility should ask the patient for his health insurance card, Temporary Eligibility Notice (see § 302.3), or other notice the patient has received from the Social Security Administration or an intermediary which shows his health insurance claim number. If the patient cannot furnish his claim number, the facility should get in touch with the transferring hospital, if it is a participating hospital, for the claim number shown on the hospital's billing form.

If the patient's health insurance claim number cannot be obtained from the above sources, the facility should request it from the SSA district office. (In addition to determining correct claim numbers, the district office can help a beneficiary replace a lost health insurance card.)

**302.1 Information Required By SSA District Office.**—If the patient's social security account number is available, the district office will usually require no additional information to locate the claim number or determine that the patient has not established health insurance entitlement.

If the patient has ever been employed or self-employed, or sought employment, or filed Federal Income Tax Returns, he should have a social security card. This card contains his social security account number which consists of 9 digits, 000-00-0000, but does not have the letter prefix or suffix which distinguishes the health insurance claim number. (See Exhibit 1.)

**A social security account number is not sufficient for processing a claim.**

If the account number is not available, the following information should be furnished:

a. The patient's name and statement as to whether or not he ever applied for social security monthly benefits, railroad retirement benefits, or for hospital insurance benefits;

b. If the patient says he applied, the name of the person on whose social security account the application was based, e.g., his own account or the account of a husband or a wife;

c. The patient's father's full name, mother's maiden name, and the patient's date and place of birth;

d. Patient's address.

If the facility cannot give all the identifying information required from the beneficiary, it should furnish as much as it has to the SSA district office.

**302.2 The SSA District Office Reply.**—The SSA district office will respond as soon as possible. If the claim number is not available, the district office will inform the facility of the action it is taking, i.e., that a claim number has been requested from SSA central records, or that it is developing an application, or an application is pending.

If an application for hospital insurance benefits is taken as a result of the request to the district office for a claim number, or is pending when the facility requests a claim number, the district office will inform the facility when processing is completed and give the facility the claim number. The facility may then send the notice of admission information to the intermediary (or to the district office if the facility deals directly with SSA).

**302.3 Temporary Eligibility Notice.**—The social security district office may under certain circumstances issue a temporary health insurance eligibility notice, pending the issuance of a health insurance card, when the beneficiary is in need of medical services. (See Exhibit 2.) The patient's name and health insurance claim number on the temporary eligibility notice should be entered on the admission notice. The intermediary will use that information for checking the Social Security Administration central record and for replying to the extended care facility about the patient's days of eligibility and deductible status.

**302.4 Intermediary Requests for Verification of Health Insurance Claim Number.**—If the name and health insurance claim number shown on the admission notice do not agree with the information shown on the SSA central beneficiary record, the admission notice will be rejected and returned to the intermediary. The intermediary will then ask the extended care facility to check its records, and check with the patient if that is feasible, for correct name and claim number information.

If unable to get corrected information from these sources, the facility should inform the social security district office that an admission notice was rejected because of incorrect name and claim number information. The district office will investigate and give the correct name and claim number to the facility, or confirm that the individual is not entitled to health insurance and has no claim number, if that is the case. The facility should report the information received from the district office to the intermediary.



### 303. ADMISSION NOTICE

A participating hospital can receive payments for a specified number of days under the hospital insurance program for inpatient services furnished a beneficiary in good faith during the period preceding receipt of the intermediary's report of eligibility, even though that report shows that as of the time of its receipt by the hospital the beneficiary's entitlement to inpatient hospital services has been exhausted for the current spell of illness. **HOWEVER, THERE IS NO SUCH GUARANTEE OF PAYMENT PROVISION IN THE LAW FOR EXTENDED CARE FACILITIES.** It is important that the extended care facility admission notice be sent as soon as possible, so that a speedy report on the patient's eligibility may be given to the facility.

The admission notice (see Exhibit 3) data sent to the intermediary should include the information called for in items 1 through 14 of the form SSA-1478; except that where item 12 applies, its completion may be delayed until the bill is submitted. The bottom two copies of the form SSA-1478 are the admission notice copies. Depending on the arrangements made with the intermediary or the social security district office, the facility may send the admission notice copies of the billing form by mail or messenger, or may submit the information from these forms by wire or telephone.

**303.1 Completing Admission Notices.**—The hospital transfer form should show the patient's name and address; health insurance claim number; dates of hospital stay; welfare agency name, address, and case number, if applicable; and a notation indicating workmen's compensation, if any. The facility should rely on this information in completing items 1, 2, 3, 5, 10, 11, and 14 of the form SSA-1478. (Additional information from the patient or hospital may be required to complete items 10 and 11.)

All entries on the form should be typed. Show month, day, and year entries in 6-digit numbers, e.g., 07/09/67.

#### 303.2 Explanation of Admission Notice Entries

**Item 1. Patient's Name.**—The patient's name should be the same as that shown on the hospital transfer form or on his health insurance card, with the last name first.

**Item 2. Health Insurance Claim Number.**—Enter the health insurance claim number as shown on the hospital transfer form, the patient's health insurance card, utilization notices, the temporary eligibility notice, or as reported by the social security district office.

**Item 3. Patient's Address.**—Enter the patient's mailing address.

**Item 4. Attending Physician.**—Enter the name of the physician who is expected to certify the medical necessity of the extended care facility stay.

**Item 5. Dates of Prior Hospital Stay.**—Enter the dates of stay in the hospital from which the patient was most recently discharged after a stay of at least 3 days. If the facility does not have in its files a hospital transfer form showing these dates, or a written report of a telephone conversation with the hospital in which these dates were furnished, then the facility should not complete item 5. If item 5 is not completed attach an explanation to the admission notice. The transferring hospital's name and address should be shown in item 11, and the intermediary will verify the prior-stay dates and enter them on the billing form.

**Items 6 and 7. Provider Identification and Provider Number.**—Enter the name and address of the extended care facility and the assigned health insurance provider number. This information may be preprinted or stamped on all copies of the form, if desired.

**Item 8. Medical Record Number.**—Enter the number, if any, used by the facility to identify the patient's medical record.

**Item 9. Date of Admission.**—Enter the date of the current admission in 6-digit numbers; e.g., 09/07/67. Show the actual date of admission even though this was before January 1, 1967.

**Item 10. Payment Source.**—Indicate who will pay for any services to the patient which will not be paid for by the health insurance program. More than one source may be checked, if applicable. If State public welfare agency payments will be made, show the name and address of the agency and the patient's case number, if known.

**Item 11. Names and Addresses of Prior-Stay Institutions.**—Enter **first** the name and address of the hospital from which the patient was most recently discharged, after a stay of at least 3 days. The first entry in item 11 should always be the name and address of the hospital to which item 5 refers.

Next enter the name and address of any extended care facility the patient entered in the period between his discharge from the hospital item 5 refers to, and his current facility admission. Also, enter the name and address of any hospital the patient may have entered in this period for a stay of less than 3 days.

The last entries in item 11 should be the names and addresses of any hospital or extended care facility (not already listed) from which the patient was discharged

in the 60-day period before the date of admission to the prior-stay hospital in item 5. This information is needed by the intermediary to determine the number of inpatient extended care facility benefit days for which the patient is eligible in the current spell of illness.

Prior-stay institutions should be listed in this item regardless of whether they are participating in the health insurance program.

**Item 12. If the Patient Received Accommodations Other Than Semi-private, Explain the Reason Why.**—This item needs to be completed only if the patient is being assigned to accommodations other than semi-private. If item 12 is not completed at the time of admission, and other than semi-private accommodations are furnished at a later date, item 12 should be completed when the bill is submitted.

If the patient is furnished private accommodations, check the appropriate block indicating the reason for this (patient's request, medical necessity, other reason). If the "medical necessity" or "other reason" block is checked, type a brief explanation in this item.

If private accommodations were medically necessary, the program will pay the reasonable cost of these accommodations. If a private room was furnished at the patient's request, the program will cover only the cost of a semi-private room, and the patient is responsible for the difference between the customary private room charges, and the most prevalent customary semi-private room charges at the time of admission. If the patient was furnished a private room and this was not at his request nor medically necessary, the program will pay only the cost of the most prevalent semi-private accommodations at that time; **and** the patient may not be charged any additional amount. (See § 212.2.A and B.)

If the patient requested a private room, show the most prevalent charge for semi-private accommodations in item 12.

If the patient is furnished ward accommodations, check the appropriate block indicating whether this was done at the patient's request or for another reason. If the "other reason" block is checked, type a brief explanation in this item. Then enter, in the space provided, the amount representing the most prevalent charge for semi-private accommodations in the facility at the time of admission. If the patient is assigned to a ward, and this was not at his request nor for a reason which the intermediary determines is consistent with program purposes, reimbursement to the facility will be based on the cost of semi-private accommodations minus the difference between the customary semi-private charges at the most prevalent rate and customary ward charges. (See § 212.C.)

To determine the most prevalent charge for semi-private accommodations:

- (1) Type of accommodation.
- (2) Total rooms of each type for each different room rate.
- (3) Total beds found in each type for each room rate.
- (4) Rate you charge daily for the type of room.
- (5) Your most prevalent charge for semi-private accommodations is that single rate that you charge for the largest entry appearing under your "total beds" column.

**Example:**

(1) Type of accommodation	(2) Total rooms of this type	(3) Total beds col. (1) x col. (2)	(4) Rate per day
2 beds .....	10	<b>20</b>	<b>\$14.00</b>
2 beds .....	8	16	15.00
3 beds .....	2	6	12.00
4 beds .....	1	4	9.00

*Note:* \$14.00 is the most prevalent semi-private charge.

**Item 13. Patient's Certification and Payment Request.**—Have the patient or his authorized representative read the statement on the form or the statement in the facility's admission record if the facility uses the alternate signature procedure (see § 250.2). If the facility obtains the signature on its own form, the signature line of the original of form SSA-1478 should be stamped to indicate that the "Patient's request for payment is on file." If the signature is obtained on form SSA-1478, it is sufficient if it is legible on the original only.

If the patient cannot sign his name because of his physical or mental condition, another person may sign on his behalf; e.g., John J. Jones by Jack A. Smith. In certain situations, a facility representative may sign on behalf of the patient. (See § 251 for who may file a payment request.)

Briefly explain the reason why the patient did not sign the form himself and show the relationship of the signer to the patient. This explanation should be retained in the facility's file if the signature is obtained on the facility's own record. If the signature is on form SSA-1478, the explanation should accompany or be included on the billing form.

The statement should be read to the patient who signs by mark. The signature by mark should be witnessed by a person who knows the patient. Enter the name



and address of any person witnessing the signature by mark.

**Item 14. Admitting Diagnoses.**—Enter the primary and secondary diagnoses. The physician's certification will indicate that inpatient extended care services are required for a condition for which the patient was receiving inpatient hospital services. Use standard nomenclature from "Standard Nomenclature of Diseases and Operations," "Current Medical Terminology, Surgical Section," and "Current Procedural Terminology."

Check the appropriate block indicating whether a workmen's compensation claim is involved. (See § 258.)

### 304. REPLY TO NOTICE OF ADMISSION

The bottom portions of the admission copies of form SSA-1478 are designed to provide eligibility information in response to the extended care facility admission notices. (See Exhibit 3.) The intermediary may use the form for this purpose, or may give the eligibility information to the facility by wire or telephone, depending upon the arrangements made between the facility and the intermediary. The direct-dealing extended care facility will receive a form reply (form SSA-1568) to the Notice of Admission from Bureau of Health Insurance, Direct Reimbursement Branch, Baltimore, Maryland.

Whether the reply is given by mail, telephone, or wire to the facility, it will contain the following eligibility information called for on the "Report of Eligibility" portion of the admission notice:

**A. Effective Date—Hospital Insurance.**—The month and year of the patient's entitlement to hospital insurance benefits (Part A) will be shown. If not entitled, the entry will so indicate.

**B. Effective Date—Medical Insurance.**—This will show the month and year of the patient's entitlement to medical insurance (Part B). The entry will so indicate if the patient is not entitled to Part B benefits.

**C. ECF Days Remaining.**—The number of extended care facility days for which payment can be made in full for the current spell of illness will be shown in the "Full" block. The number of days remaining, for which the patient must pay the coinsurance amount, will be shown in the "Coinsurance" block. "None" will be shown where applicable.

**D. Pints Remaining—Blood Deductible.**—This item is for informational purposes.

**E. 3-Day Hospital Stay Requirement.**—The intermediary will complete this item to show whether this requirement is "Met" or "Not Met."

**F. 14-Day Transfer Requirement.**—The intermediary will complete this item to show whether the 14-day requirement is "Met" or "Not Met."

**G. HHA Visits Remaining—Hospital Insurance and Medical Insurance.**—The number of home health visits remaining under Part A will be shown. Remaining home health visits under Part B will not be routinely shown in replying to extended care facility Notices of Admission.

**H. Medical Plan Deductible.**—The status of this deductible will be indicated by a checkmark in the block designated "Met" or "Not Met." If the deductible is not met, the amount remaining to be met will not be shown. If the reply shows the deductible is "Not Met," and Part B services have been furnished, the extended care facility should ask the patient whether he has had any previous Part B expenses which could be counted toward the deductible. (See § 115.3.) The facility should try to determine whether the patient has satisfied the Part B deductible before charging him this amount.

The intermediary will determine the patient's exact Part B deductible status upon receipt of the facility's bill.

**I. Open Item Information.**—The information in this block will be completed by the intermediary when verifying reports of "extended care facility open items" (admissions recorded in SSA central records, but not closed out by processing of a bill).

Where there is an extended care facility open item reported from the SSA central record, this "open item" must be processed before the current bill can be processed. The intermediary (or the SSA Direct Reimbursement Branch in the case of a direct-dealing provider) will get in touch with the "open item" provider to verify the stay, the date of the prior discharge, and status of the bill. The intermediary will use the prior stay information to compute the remaining days of eligibility.

**Remarks.**—Any necessary explanation of eligibility information will be shown. This will include corrections in the name or health insurance claim number reported by the facility. When changes of this sort are reported, the name and claim number information on the billing form should be changed accordingly.

If name and claim number information were not matched, the intermediary will request the facility to verify the claim number. (See § 302.4.)

### 305. RETROACTIVE ENTITLEMENT

It may happen that an individual over 65 years of age does not establish his entitlement to hospital insurance benefits until after his discharge from an ex-



tended care facility. In such a case, payment may be made for extended care service furnished in a retroactive period of up to 12 months, but not before January 1, 1967. When a beneficiary inquires about retroactive entitlement, he will usually have a Social Security Administration notice which prompted his inquiry. In these cases, the facility should follow the Notice of Admission procedure to verify the patient's eligibility. When this is verified, the facility should refund to the patient any payments he made for services which are covered by the program, and submit a bill to the intermediary.

### **306. INITIATING NOTICES OF ADMISSION WHERE NO PAYMENT WILL BE MADE**

§ 405 explains that extended care facilities will submit billing forms even when no payments under the program may be made. In most such cases, Notices of Admission will have been initiated as a normal course of procedure to determine the patient's eligibility. However, there will be some situations where, at admission, the individual states that benefits have been exhausted in the current spell of illness. The extended care facility should nevertheless initiate a Notice of Admission. This notice will serve to verify that the

patient has in fact no remaining eligibility, and also help to keep the beneficiary's utilization record current.

Notices of Admission should also be sent even though workmen's compensation has paid or can be expected to pay the entire bill, the services are not covered, the 3-day hospital stay and 14-day transfer requirement are not met, or the patient refuses to request payment.

Where the patient refuses to request payment and does not furnish his health insurance claim number, the facility should get in touch with the SSA district office for assistance in obtaining this number. If the patient refuses to request payment which could otherwise be made on his behalf, his utilization record must nevertheless be charged for covered extended care services furnished him.

After the report of eligibility is received in such no-payment cases, billing forms should be forwarded, to keep the patient's utilization record current, in accordance with § 405.



### **399. EXHIBITS**

Exhibit 1. Health Insurance Cards and Claim Numbers

Exhibit 2. Temporary Eligibility Notice

Exhibit 3. Extended Care Admission and Billing (Admission Copy)—Form SSA-1478

## HEALTH INSURANCE CARDS

Health  Insurance	
SOCIAL SECURITY ACT	
NAME OF BENEFICIARY <b>JANE Q. DOE</b>	
CLAIM NUMBER <b>000-00-0000B</b>	SEX <b>FEMALE</b>
IS ENTITLED TO	EFFECTIVE DATE
HOSPITAL INSURANCE	<b>7-1-66</b>
MEDICAL INSURANCE	<b>7-1-66</b>
SIGN HERE 	

Front

1. Carry your card with you when you are away from home.
2. Let your hospital or doctor see your card when you require hospital, medical or health services under "Medicare."
3. Get in touch with your social security office if you have questions about your rights under "Medicare."
4. Your card is good wherever you live in the United States.



WARNING: Issued for the sole use of the holder designated hereon. Intentional misuse of this card is unlawful and will make the offender liable to penalty.

PROPERTY OF UNITED STATES GOVERNMENT.  
IF FOUND DROP IN NEAREST U.S. MAIL BOX.

Return To: SOCIAL SECURITY ADMINISTRATION  
Baltimore, Maryland 21235

Form SSA-1966 (7-66)

Back

Health  Insurance	
RAILROAD RETIREMENT BOARD	
NAME OF BENEFICIARY <b>JOHN C. DOE</b>	
CLAIM NUMBER <b>A-000-00-0000</b>	SEX <b>MALE</b>
IS ENTITLED TO	EFFECTIVE DATE
HOSPITAL INSURANCE	<b>7-1-66</b>
MEDICAL INSURANCE	<b>7-1-66</b>
SIGN HERE 	

Front

1. Carry your card with you when you are away from home.
2. Let your hospital or doctor see your card when you require hospital, medical or health services under "Medicare".
3. Get in touch with your Railroad Retirement Board office if you have questions about your rights under "Medicare."
4. Your card is good wherever you live in the United States. For benefits in Canada, write to the Railroad Retirement Board.

WARNING: Issued for the sole use of the holder designated hereon. Intentional misuse of this card is unlawful and will make the offender liable to penalty.

PROPERTY OF UNITED STATES GOVERNMENT.  
IF FOUND DROP IN NEAREST U.S. MAIL BOX.

Return to: RAILROAD RETIREMENT BOARD  
844 Rush Street, Chicago, Illinois 60611

Form G-43 (2-66)

Back

## HEALTH INSURANCE CLAIM NUMBERS

Most HI claim numbers are 9 digits with a letter or letter and numeral suffix; e.g., 000-00-0000B or B1. They may also be 6-or-8-digit numbers with lettered prefixes; e.g., A000000, A-000-00-0000; or WD-000000, WD-000-00-0000. Numbers with one or more letter prefixes identify Railroad Retirement Board annuitants.

Possible suffixes are:

A, B, B1, B2, B3, B4, B5, B6, or B9

C1, C2, C3, C4, C5, C6, C7, C8, or C9

D, D1, D2, D3, D4, D5, D6, or D7

E, E1, E2, or E3

F1, F2, F3, F4, F5, F6, F7, or F8

HB, HB1, HB2, HB3, HB4, HB5, HB6, or HB9

HC1, HC2, HC3, HC4, HC5, HC6, HC7, HC8, or HC9

J1, J2, J3, J4 (For subscripts "3" and "4" there can be no entitlement to hospital insurance benefits. Supplementary medical insurance entitlement may exist for all J and K suffixes.)

M, M1, and T (Suffix letter "T" indicates entitlement to hospital or hospital and medical insurance; letters M and M1 indicate that the patient is eligible for supplementary medical insurance benefits but not for hospital insurance benefits.)





EXHIBIT 2

TEMPORARY NOTICE OF ELIGIBILITY

District Office Address:

Date:

Dear :

Based on the information you have given to the Social Security Administration you will be eligible for hospital insurance benefits beginning (mo.) (yr.) and for supplementary medical insurance benefits beginning (mo.) (yr.). Your eligibility will continue for 60 days from the date shown at the top of this notice unless you are notified otherwise during the 60-day period.

To obtain medical services before you receive your card, show this letter to your hospital or doctor but keep the letter with you. This temporary notice of eligibility is to be used only by the person to whom it is addressed. Misuse is unlawful and will make the offender liable to a penalty.

This letter should be destroyed as soon as you receive your health insurance card or other notice concerning your eligibility.

Sincerely yours,

Robert M. Ball  
Commissioner of Social Security

IMPORTANT

When services are provided on the basis of this notice, all bills or correspondence with an intermediary or the Social Security Administration should show the patient's social security claim number.



## EXHIBIT 3

## EXTENDED CARE ADMISSION AND BILLING

DEPARTMENT OF HEALTH, EDUCATION, AND WELFARE SOCIAL SECURITY ADMINISTRATION			
EXTENDED CARE ADMISSION AND BILLING HOSPITAL INSURANCE BENEFITS - SOCIAL SECURITY ACT			
Form Approved Budget Bureau No. 72-R765			
1. PATIENT'S LAST NAME		2. HEALTH INSURANCE CLAIM NUMBER	
3. PATIENT'S ADDRESS (Street number, City, State, Zip Code)		4. NAME OF ATTENDING PHYSICIAN	
5. DATES OF PRIOR HOSPITAL STAY ADMISSION      DISCHARGE		6. EXTENDED CARE FACILITY NAME AND ADDRESS	
7. PROVIDER NUMBER		8. MEDICAL RECORD NO.	
9. DATE OF THIS ADMISSION		10. PAYMENT SOURCE FOR CHARGES TO PATIENT	
		<input type="checkbox"/> SELF OR FAMILY <input type="checkbox"/> BLUE CROSS <input type="checkbox"/> PUBLIC AGENCY <input type="checkbox"/> BLUE SHIELD    (Give name) <input type="checkbox"/> PRIVATE INSURANCE <input type="checkbox"/> EMPLOYER OR UNION <input type="checkbox"/> OTHER (Explain)	
11. NAMES AND ADDRESSES OF ALL HOSPITALS AND EXTENDED CARE FACILITIES FROM WHICH PATIENT WAS DISCHARGED IN PAST 60 DAYS. (If this ECF, give dates of stay).			
12. REASON FOR OTHER THAN SEMI-PRIVATE ACCOMMODATIONS: <input type="checkbox"/> PATIENT'S REQUEST <input type="checkbox"/> MEDICAL NECESSITY (Describe) <input type="checkbox"/> OTHER REASON (Specify)			
Most Prevalent Semi-Private Rate \$ _____			
13. PATIENT'S CERTIFICATION, AUTHORIZATION TO RELEASE INFORMATION, AND PAYMENT REQUEST. I certify that the information given by me in applying for payment under Title XVIII of the Social Security Act is correct. I authorize release of all records required to act on this request. I request that payment of authorized benefits be made on my behalf.			
SIGNATURE (Patient or authorized representative) (Signature by mark must be witnessed)			DATE
14. ADMITTING DIAGNOSES			DO NOT USE THIS SPACE
(a) Primary    EMPLOYMENT RELATED <input type="checkbox"/> YES <input type="checkbox"/> NO			
(b) Secondary			
REPORT OF ELIGIBILITY			
A. Effective Date—Hospital Insurance		1. Open Item Information 1. Intermediary	
B. Effective Date—Medical Insurance			
C. ECF days remaining	FULL      COINSURANCE	2. Provider	
D. Pints remaining blood deductible			
E. 3 day hospital stay requirement	<input type="checkbox"/> MET <input type="checkbox"/> NOT MET	3. Date Admitted	
F. 14 days transfer requirement	<input type="checkbox"/> MET <input type="checkbox"/> NOT MET		
G. HHA visits remaining	HOSPITAL INS.    MEDICAL INS.	4. Date Discharged	
H. Medical plan deductible	<input type="checkbox"/> MET <input type="checkbox"/> NOT MET		
REMARKS			
INTERMEDIARY APPROVAL		DATE	

FORM SSA-1478 (10-66)

ADMISSION COPY





## Chapter IV

### BILLING PROCEDURES

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EXTENDED CARE ADMISSION AND BILLING  
HOSPITAL INSURANCE BENEFITS - SOCIAL SECURITY ACTForm Approved  
Budget Bureau No. 72-R765

1. PATIENT'S LAST NAME		FIRST NAME		MI	2. HEALTH INSURANCE CLAIM NUMBER	
3. PATIENT'S ADDRESS (Street number, City, State, Zip Code)					4. NAME OF ATTENDING PHYSICIAN	
5. DATES OF PRIOR HOSPITAL STAY ADMISSION      DISCHARGE		6. EXTENDED CARE FACILITY NAME AND ADDRESS			7. PROVIDER NUMBER	
9. DATE OF THIS ADMISSION					8. MEDICAL RECORD NO.	
		10. PAYMENT SOURCE FOR CHARGES TO PATIENT <input type="checkbox"/> SELF OR FAMILY <input type="checkbox"/> BLUE CROSS BLUE SHIELD <input type="checkbox"/> PUBLIC AGENCY (Give name) <input type="checkbox"/> PRIVATE INSURANCE <input type="checkbox"/> EMPLOYER OR UNION <input type="checkbox"/> OTHER (Explain)				
11. NAMES AND ADDRESSES OF ALL HOSPITALS AND EXTENDED CARE FACILITIES FROM WHICH PATIENT WAS DISCHARGED IN PAST 60 DAYS. (If this ECF, give dates of stay).						
12. REASON FOR OTHER THAN SEMI-PRIVATE ACCOMMODATIONS: <input type="checkbox"/> PATIENT'S REQUEST <input type="checkbox"/> MEDICAL NECESSITY (Describe) <input type="checkbox"/> OTHER REASON (Specify)						
Most Prevalent Semi-Private Rate \$						
13. PATIENT'S CERTIFICATION, AUTHORIZATION TO RELEASE INFORMATION, AND PAYMENT REQUEST. I certify that the information given by me in applying for payment under Title XVIII of the Social Security Act is correct. I authorize release of all records required to act on this request. I request that payment of authorized benefits be made on my behalf.						
SIGNATURE (Patient or authorized representative) (Signature by mark must be witnessed)					DATE	
14. ADMITTING DIAGNOSES (a) Primary  (b) Secondary					DO NOT USE THIS SPACE	
15. DISCHARGE OR CURRENT DIAGNOSES (a) Primary  (b) Secondary						
16. STATEMENT OF SERVICES RENDERED			TOTAL INPATIENT CHARGES	NON-COVERED CHARGES	20. STATEMENT COVERS PERIOD FROM      THRU	
ACCOMMODATIONS	DAYS	RATE			22. DATE UR NOTICE RECEIVED	
A. 1-Bed					23. DATE BENEFITS EXHAUSTED	
B. 2-3-4 Bed					24. TOTAL DAYS	
C. 5 or more beds					25. <input type="checkbox"/> DISCHARGED <input type="checkbox"/> DIED <input type="checkbox"/> STILL PATIENT	
D. Physical Therapy					26. DATE DISCHARGED OR DIED	
E. Occupational Therapy					27. COMPUTATION OF INTERIM PAYMENT	
F. Speech Therapy						
G. Pharmacy						
H. Other (Describe)						
I. TOTALS			\$			
17. Coinsurance      Days@			\$	Reimbursement Amount \$		
18. Part B Services Furnished to other than Inpatients				CHARGES	INTERMEDIARY USE	
				\$	VERIFIED PRIOR STAY DATES	
					28. QUALIFYING HOSPITAL      BEGINNING THRU      PROVIDER NUMBER	
TOTALS					28a. OTHER	
19. Part B Charges paid by Patient				\$	29. SEMI-PRIVATE DIFFERENTIAL \$	
32. I certify that the required Physician's certification and recertifications are on file.					30. PART B DEDUCTIBLE      30a. COINSURANCE      31. REFUND TO PATIENT	
SIGNATURE OF EXTENDED CARE FACILITY REPRESENTATIVE				DATE FWD.	\$      \$      \$	
					33. APPROVED BY      DATE	



## Chapter IV

### BILLING PROCEDURES

#### 400. SUMMARY OF BILLING PROCEDURES

The Extended Care Admission and Billing Form SSA-1478 was designed for extended care facility billing for services reimbursable under the program on a reasonable cost basis. A facility should use Form SSA-1554, Provider Billing For Patient Services By Physicians, to bill for reasonable charge reimbursement for facility-based physician services to patients. (See § 215 for definition.) The Form SSA-1478 will be processed by the Part A intermediary, and the Form SSA-1554 will be processed by the Part B intermediary.

The upper section of the SSA-1478 (items 1 through 14) should be completed on all six copies at the time of admission. The lower or billing section of the form (items 15 through 32) should be completed when the patient is discharged or when his benefits are exhausted, whichever occurs first. (It is not necessary to submit a billing form each time a patient has a leave of absence.) The benefit status data needed to complete the form will be given in the SSA reply to the notice of admission. The billing copies of the form should then be sent to the intermediary (or to the Social Security Administration if the facility deals direct).

The bill may also be submitted on an interim basis, for example, every 30 days. The admission notice need not be completed for subsequent billings for the same extended care facility stay, and the patient's signature is not needed for such subsequent billings.

A billing form should be submitted, even though no benefits may be payable, to enable the Social Security Administration to keep the patient's utilization record current (see § 405), and to close out the admission notice sent in "no-payment" cases.

#### 401. LIST OF AUTHORIZED SIGNATORIES

Each extended care facility should submit to its Part A intermediary a listing of officials it has authorized to sign and certify bills and supporting statements. The listing should be kept current.

#### 402. COMPLETION OF BILLING ITEMS ON FORM SSA-1478

*Item 15. Discharge or Current Diagnoses.*—If this is an interim bill the current diagnoses should be shown.

The primary diagnosis should appear first. Then list any secondary diagnoses. Standard nomenclature should be used (refer to "Standard Nomenclature of Diseases and Operations," "Current Medical Terminology," and "Current Procedural Terminology").

*Item 16. Statement of Services Rendered.*—Enter all charges by each department for the period covered by the current billing. Where the facility has more departments than those shown on the form, combine the charges, where appropriate. Any charge which cannot be applied to one of the items shown should be described in item 16H—"Other."

Enter all charges—covered and noncovered—in the "Total Inpatient Charges" column. Charges for noncovered services and items, except for the services of facility-based physicians, should be itemized in the "Noncovered Charges" column. Charges for all noncovered days which fall within the period described in item 20 (on a bill covering both covered and noncovered days, or noncovered days only) should also be shown in the "Noncovered Charges" column. If it is necessary to explain an item, a statement may be attached. Any statement attached should show the patient's name and claim number. Only one copy is needed. (Details concerning coverage are contained in Chapter II. See § 405 on submitting bills for noncovered days.)

If the facility and the intermediary agree, the facility may use machine-produced ledger sheets to report services and charges. The ledger sheets submitted should show total charges for each department. Hotel-type billings which summarize by day but not by department are not acceptable.

Where ledger sheets are submitted in lieu of item 16, each ledger sheet attached should show the patient's name and claim number.

Unless the days, rate, and type of accommodation are clearly shown on the machine bill, the accommodation entries on the form SSA-1478 should be completed. The facility should complete item 12 on the billing form, where applicable. The facility should also complete items 17, 18, and 19, unless the coinsurance, Part B services and charges, and Part B charges paid by the

patient are clearly shown on the attached machine bill.

**Item 16A. 1-Bed Accommodation.**—Where a patient needed a private room for medical reasons, explain the medical necessity in item 12. The medical necessity should be described by the doctor in the patient's medical record or other document retained by the facility. Enter the customary charge for a 1-bed accommodation in the "Rate" column and complete the "Total Inpatient Charges" column.

If the patient requested a 1-bed accommodation, payment cannot be made for more than the cost of semiprivate accommodations. The patient is responsible for the difference between the customary private room charges and the most prevalent semiprivate room charges at the time of admission. The charge for the 1-bed accommodation should be entered in the "Rate" column, and the product of this rate times the number of days should be shown in the "Total Inpatient Charges" column. Show the total charges to the patient in the "Noncovered Charges" column.

Check the "Patient's Request" block in item 12, and enter the most prevalent semiprivate rate in the space provided in item 12. (See § 303.2, Item 12, for computation of the most prevalent rate.)

If private accommodations were furnished and this was not medically necessary nor at the patient's request, the facility should check the "Other Reason" block and give a brief explanation in item 12. In this case the program will cover only the cost of semiprivate accommodations and no charge may be made to the patient. The facility should use line 16B and the semiprivate rate should be shown in the "Rate" column, even though private accommodations were actually furnished. The "Total Inpatient Charges" column should show the total charges for semiprivate accommodations. Since no additional charge can be made to the patient in this situation, no entry should be made in the "Noncovered Charges" column.

**Item 16B. 2-3-4-Bed Accommodation.**—If the patient occupied semiprivate accommodations, show the number of days, the semiprivate rate, and the total charges.

**Item 16C. 5-Or-More-Bed Accommodation.**—If the patient is in an accommodation of 5-or-more beds, show the number of days, the ward rate, and the total charges.

Item 12 must be completed to explain the reasons for this accommodation. If the patient did not request the ward accommodations, the amount representing the most prevalent customary charge for semiprivate accommodations at the time of admission should be shown

in the space provided in item 12. (See § 303.2, Item 12.)

If the ward accommodation was not requested by the patient nor provided for a reason consistent with the purposes of the health insurance program, the intermediary will subtract the total ward charges from the total semiprivate charges as determined by using the rate entered in item 12, and enter the difference in item 29, "Semi-Private Differential." Payment to the extended care facility must be reduced at the end-of-the-year settlement by the amount of such differentials. (See § 212.2C.)

**Items 16D Through H.** Enter all charges for supplies or services—covered or noncovered—in the "Total Inpatient Charges" column. Show charges for noncovered services and items in the "Noncovered Charges" column. When there is insufficient space to describe all services performed in item 16H (Other), a separate attachment for such services and charges may be used. Continuation sheets should **not** be used.

Where items and services, which are in excess of or more expensive than those covered by the program, are requested by the patient the difference between the amount customarily charged for the items or services requested, and the amount customarily charged for the items or services covered by the program, should be shown as noncovered charges.

**Item 16I. Totals.**—Enter the total inpatient charges and the total noncovered charges.

**Item 17. Coinsurance.**—Enter the \$5 daily coinsurance charge, if applicable, and the number of days covered by this bill which fall in the coinsurance period (which begins with the 21st inpatient extended care facility day in a spell of illness). Multiply the number of days by \$5 and show that amount in the money column.

**Item 18. Part B Services Furnished to Other than Inpatients.**—Enter Part B services, such as transportation furnished in an extended care facility ambulance, in this item. If facility-based physician charges are ordinarily included in total charges to the patient, these charges should be included in item 16. They should **not** appear in item 18.

**Item 19. Part B Charges Paid by Patient.**—Enter here any Part B deductible and/or coinsurance amount paid by the patient. (See § 115.3.) The facility should try to learn from the patient whether he had any previous Part B services which could count toward the Part B deductible before collecting that amount from the patient. If the deductible is met, the patient is responsible for the 20 percent coinsurance amount. The intermediary will refund directly to the patient any



Part B deductible overcollection made by the facility.

**Item 20. Statement Covers Period.**—Enter the beginning and ending dates of the period covered by this statement. The beginning date of this period should be no earlier than January 1, 1967, even though the admission date in item 9 may be earlier than that.

Where the patient is still in the facility, show the last day of the period being reported on the bill, whether or not this last day was a day of covered service. Otherwise, show the date of discharge or death. (See § 405 for information on completing the form after benefits have been exhausted.)

**Item 21. Leave Days.**—Enter the number of days on which the patient was not present in the extended care facility at midnight and for which the facility is not being reimbursed. Attach a brief explanation to the billing form.

It is not necessary to complete a notice of admission and billing form each time a leave of absence occurs.

**Item 22. Date UR Notice Received.**—Enter the date the extended care facility received the notice from the Utilization Review Committee (or the group responsible for the review of utilization) that further stay by the patient is not medically necessary.

**Item 23. Date Benefits Exhausted.**—Enter the date on which the patient's benefits were exhausted, if this occurred before the beneficiary's discharge or death and during the period described in item 20. Make no entry in this space when the Reply to the Notice of Admission showed **no** days remaining.

**Item 24. Total Days.**—Enter here the total days of covered extended care facility care for the period shown in item 20. Count the day of admission, but do not count the day of discharge. Do not count days for which payment cannot be made because benefits were exhausted, a workmen's compensation payment was made or expected (attach an explanation), or because a utilization review notice was received stating that extended care facility care was no longer necessary. (Payment may be made for 3 benefit days after the day such notice was received.) Do not count "leave of absence" days.

**Items 25 and 26. Discharge Information.**—If the patient is still in the extended care facility when the billing is submitted, check "Still Patient." Otherwise, check "Discharged" or "Died" in item 25. Show the date of discharge or death in item 26.

**Item 27. Computation of Interim Payment.**—Payments to the facility under the hospital insurance plan are based on the reasonable cost of service provided. The precise reasonable cost of services cannot be determined until the end of the year when final cost fig-

ures are known. However an interim settlement will be made on the basis of each bill. This interim settlement method will be worked out by the intermediary and the extended care facility. If the facility wishes to make a computation for its own records, it should do so on the Extended Care Facility copy of the form or on a separate sheet. It can estimate the cost of covered services by the approved method and subtract any applicable deductible and coinsurance to arrive at the reimbursement amount.

A separate computation should be made for any Part B services furnished.

**Items 28 Through 31.** For intermediary use.

**Item 32. Extended Care Facility Certification and Signature Line.**—An extended care facility representative should make sure that the required physician's certification and recertification are on file. The representative should then sign and date the form before it is submitted to the intermediary.

**Item 33. Approved By and Date.**—For intermediary use.

**402.1 Disposition of Copies of Completed Forms SSA-1478.**—Retain the copy marked "Extended Care Facility Copy." The following remaining copies should be submitted to the intermediary (or to the Bureau of Health Insurance, Direct Reimbursement Branch, Baltimore, Maryland, in a direct-dealing situation) :

- a. The original copy, which will be maintained in the intermediary's (or SSA's) files.
- b. The copy marked "Social Security Copy."
- c. The copy marked "Carrier Copy," for the Part B intermediary to associate with any related physicians' bills.

#### **404. PROVIDER BILLING FOR PATIENT SERVICES BY PHYSICIAN (FOR SSA-1554)**

A. This form is used to bill for facility-based physicians' services to patients (see § 215) where:

1. The beneficiary assigns payment to the physician,
2. The physician agrees that the reasonable charge, as determined by the intermediary, will be the full charge for services rendered and,
3. The physician has authorized the extended care facility to accept the assignment and collect the payment on his behalf.

The form should be attached to the extended care facility bill for the stay or services to which the physicians' charges apply. It should be forwarded with the SSA-1478 to your regular intermediary for provider services. Your intermediary will forward it to





## PROVIDER BILLING FOR PATIENT SERVICES BY PHYSICIANS

Form Approved.  
Budget Bureau No. 72-R747

(Use this form only where the provider has billing arrangement to collect physician charges for individual patient care pursuant to agreement with the physician.)

1. PATIENT'S LAST NAME	FIRST NAME	MI	2. HEALTH INSURANCE CLAIM NUMBER
3. PATIENT'S ADDRESS (Street number, City, State, Zip Code)	4. DATE OF BIRTH		
6. NAME AND ADDRESS OF PROVIDER	5. SEX		8. MEDICAL RECORD NO.
	<input type="checkbox"/> M <input type="checkbox"/> F		
7. PROVIDER NO(S)			

9. ASSIGNMENT: I assign payment for unpaid charges of the physician(s) listed on this form.

**AUTHORIZATION:** I authorize release of any information required to act on this claim and permit a photographic reproduction of this authorization to be used in place of the original.

The above information is correct. I request payment on my behalf for the medical insurance benefit, if any, payable for the reasonable charges for services described. I understand I am responsible for any medical insurance deductible and 20% of the remaining reasonable charges.

SIGNATURE OF PATIENT (Or his representative)										DATE SIGNED	
10A.	B.	C.	D.	E.	F.	G.	H.	LEAVE			
DATE OF EACH SERVICE	NAME OF PHYSICIAN	PLACE OF SERVICE H, O, I, C, F, H	FULLY DESCRIBE SURGICAL OR MEDICAL PROCEDURES	DEPARTMENT	TOTAL CHARGE WHEN APPLICABLE	PERCENTAGE OF TOTAL CHARGE WHEN APPLICABLE	CHARGE FOR PHYSICIANS SERVICES	BLANK			
11. DIAGNOSES AND CONCURRENT CONDITIONS										TOTALS \$	
12. EMPLOYMENT RELATED <input type="checkbox"/> YES <input type="checkbox"/> NO (If yes, give name and address of employer)											
										Deductible and coinsurance paid	
										Any unpaid balance	

113. PROVIDER CERTIFICATION: The physicians named in item 10B have authorized the provider to accept assignment and receive payments in their behalf (and such authorizations are on file and still in effect.)

SIGNATURE OF PROVIDER REPRESENTATIVE	DATE
--------------------------------------	------

the carrier for physicians' services with his copy of the regular billing form.

Do not use Form SSA-1554 to report the services of a physician who wishes the medical insurance payment to be made directly to himself. Inform that physician that he and the patient may complete a medical insurance benefits claims form (Request for Payment, Form SSA-1490) for that purpose. A patient who has been billed directly by a physician may also use this form to claim medical insurance payments from the carrier.

B. The following is a sample of an authorization for use by providers in connection with provider billing for facility-based physicians' services. *A one-time execution of this authorization is all that is necessary by each physician.* The authorization should be retained in the provider's files.

"I hereby authorize the (name of institution) or any of its duly authorized administrators to accept on my behalf any assignment made by any individual who receives medical treatment from me at the (name of institution) of the amount payable to such individual under Part B of Title XVIII of the Social Security Act and to receive on my behalf any payments which may be made pursuant to such assignment. It is understood and agreed that the reasonable charge which will serve as the basis for payment in accordance with the terms of such assignment shall be the full charge for the services."

An additional statement should also include the individual arrangements agreed upon by the provider and the physician governing the conditions of withdrawing the authorization.

#### **404.1 Completing Items on Form SSA-1554.—**

**Item 1. Patient Identification.**—The patient's name should be the same as that shown on his health insurance card with the last name first.

**Item 2. Health Insurance Claim Number.**—Enter the health insurance claim number shown on the patient's health insurance card or related extended care facility billing form.

**Item 3. Patient's Address.**—Show the address of the person who is assigning benefits, whether this is the patient or someone acting on his behalf.

**Items 4 and 5. Date of Birth and Sex.**—Complete the "Date of Birth" and "Sex" blocks. If the date of birth is unknown, the facility should transmit the bill without the date of birth. If only the year of birth is known, but not the month or day, show the year. While the date of birth is useful as identification and should

be shown when available, a billing may be processed without the date of birth.

**Items 6 and 7. Provider Identification.**—Enter the name and address of the facility and the assigned health insurance provider number. These entries may be stamped or preprinted.

**Item 8. Medical Record Number.**—Show the patient's medical record number if one is assigned by the provider.

**Item 9. Authorization and Signature.**—Have the patient or his authorized representative read the statement on the form or the statement in the facility admission record if the facility uses the alternate signature procedure (see § 250.2). If the facility obtains the signature on its own form, the signature line of Form SSA-1554 should be stamped to indicate that the "Patient's request for payment is on file."

If the patient cannot sign his name because of his physical or mental condition, another person may sign on his behalf; e.g., John J. Jones by Jack A. Smith. In certain situations, an extended care facility representative may sign on behalf of the patient. (See § 251 for who may file a payment request.)

Briefly explain the reason why the patient did not sign the form himself and show the relationship of the signer to the patient. This explanation should be retained in the facility's file if the signature is obtained on the facility's own record. If the signature is on Form SSA-1554, the explanation should accompany or be included on the billing form.

The statement should be read to the patient who signs by mark. The signature by mark should be witnessed by a person who knows the patient. Enter the name and address of any person witnessing the signature by mark.

**Item 10A. Date of Service.**—Show the date for each service when the "item-by-item" method is used to bill for physician charges. Inclusive dates may be shown only where the provider and physician arrange to use the "optional" method to bill such charges (see § 404.3).

**Item 10B. Name of Physician.**—Show the name of the physician for whom the facility is billing for services. Upon arrangement with the intermediary, billing may be in the name of the facility department head. This item should be omitted when billing for services by the "optional" method (see § 404.3).

**Item 10C. Place of Service.**—Enter code: "ECF."

**Item 10D. Surgical or Medical Procedures.**—Except where the "optional" method is used in determining physicians' charges, give the medical laboratory, and



X-ray procedures performed for each date during the billing period. The procedures should be clearly identified by the use of standard nomenclature.

Where the "optional" method is used, services are identified on a departmental basis in item 10E and this space is left blank. (See § 404.3.)

**Item 10E. Department.**—Enter the name of the department associated with the physician's services; e.g., X-ray, or laboratory.

**Items 10F and 10G. Total Charge and Percentage of Total Charge.**—If the provider and the physician agree to bill for physician charges using the "optional" method, enter in item 10F the provider's total charges where the charges are combined charges for extended care facility and physician services shown in item 10E. Show in item 10G the approved percentage of the total departmental charge entered in item 10F. Items 10F and 10G are used only where the "optional" method has been agreed upon by the extended care facility and physician and approved by the intermediaries (see § 404.3).

Details as to distinguishing the physician charge from costs which are reimbursable to the extended care facility under the hospital plan are contained in the provider reimbursement principles.

**Item 10H. Charge for Physicians' Services.**—Enter the money amount attributable to physicians' services. Total all physicians' charges and enter the amount in the "Totals" block. Show any part of the \$50 deductible and coinsurance paid by the patient and subtract the amount paid from the total charges.

**Item 11. Diagnosis and Concurrent Conditions.**—Show the most significant of the conditions first in entering diagnoses. Use recognized nomenclature such as that contained in "*Current Medical Terminology, Standard Nomenclature of Diseases and Operations*," and the American Psychiatric Associations' "*Diagnostic and Statistical Manual*," etc. Show any concurrent conditions associated with the primary diagnosis.

**Item 12. Employment Related.**—Indicate whether the condition is employment related. If the condition is or may be employment related, give the name and address of the employer, if known. Payment may be made subject to reimbursement if a workmen's compensation claim is pending and no settlement is foreseeable. (See §§ 258ff.)

**Item 13. Provider Certification Signature, and Date.**—The signature of the facility representative serves as a request for payment on behalf of physicians. The signature is also a certification that proper authorizations are on file and are still in effect.

**404.2 Disposition of Form SSA-1554.**—Since

this form has only a single copy, the facility may wish to make a carbon copy when preparing the form, for its own files. The original should be attached to the extended care facility bill and forwarded to the intermediary for provider services. Where no extended care facility bill is being submitted, send the form direct to the intermediary for physicians' services.

**404.3 Description of "Item-by-Item" and "Optional" Methods for Physicians' Components.**—When the "item-by-item" method is used, the facility and physicians determine a schedule of separate identifiable charges for each procedure. This schedule is filed with the Part A and Part B intermediaries after agreement is reached with them regarding the appropriateness of all charges. (See § 215.)

A detailed reporting of the surgical or medical procedures is required to enable intermediaries to approve and make payment for physician services under supplementary medical insurance (Part B) in accordance with the schedule of charges established by the provider and physician. Under this method of determining the physician's charge, an itemization of services is necessary.

Under the optional method, the charges for services of a provider-based physician are determined by applying a single uniform percentage of the combined charge for facility and physician services. The percentage established by the facility and the physician must be approved by and filed with the intermediaries and will be used in determining the charge for physician services.

Where the optional method is followed, it will not be necessary for providers to identify the surgical or medical procedure in item 10D of the Provider Billing for Patient Services by Physicians. It will be sufficient to indicate the department by name, i.e., laboratory, radiology, etc., in item 10E. The total combined departmental charge for each department and the applicable single uniform percentage must be entered in columns 10F and 10G.

## **405. SUBMITTING BILLING FORMS IN NO-PAYMENT CASES**

The SSA maintains a record of inpatient hospital and extended care facility benefits paid for each beneficiary. To determine whether a new spell of illness has begun after such payment has been made, the Social Security Administration must know whether there has been a period of 60 consecutive days, following the last day of covered extended care facility or hospital inpatient services, during which the beneficiary was not an inpatient of any hospital or extended care facility, participating or nonparticipating. For this reason once



a spell of illness has begun, all subsequent hospital and extended care facility stays must be reported to the Social Security Administration, regardless of whether hospital insurance benefits are payable for such stays.

Information obtained by the extended care facility from the patient and entered in item 11 of the form SSA-1478 will alert the intermediary to prior stays in both participating and nonparticipating institutions and the need for updating the patient's utilization record. In addition to this, however, all participating extended care facilities should submit billing forms reporting extended care facility stays by beneficiaries, even though no payment can be made to the extended care facility, to help assure that accurate and current beneficiary utilization records are maintained.

Specifically, the extended care facility should submit a billing form:

- for the period from the date benefits were exhausted until the patient's discharge or death;
- for an inpatient extended care facility stay for which payment is made or can be expected by a workmen's compensation plan;
- for an inpatient extended care facility stay when the 3-day prior hospital stay or 14-day transfer requirements were not met, or when the services were not covered for some other reason;
- for the period beginning with the fourth day after a utilization review notice (concerning the lack of medical need for further extended care facility

services) is received, and ending with the date of discharge or death.

—where the patient has refused to sign a request that payment be made on his behalf. (See § 306.)

When an extended care facility submits a billing form in one of these cases where no payment can be made, only the following items on the billing form should be completed: Items 1 through 3, 5 through 7, 9 through 11, 14, 15, 16I, 18, 20, 25, and 32.

Billing forms should be submitted in no-payment cases every 60 days until the patient's discharge or death. However, where both noncovered and covered days are reported on the bill, all the items must be completed. When noncovered days are included in the period covered by the bill, the extended care facility should include a brief explanation (except in a "benefits exhausted" case) on an attachment to the billing form.

#### **406. PROCEDURES FOR SUBMITTING CORRECTED BILLS**

The extended care facility may discover that a bill already submitted is incorrect. To correct a previously submitted bill, the extended care facility should reproduce a copy of it and make the necessary corrections in the appropriate items. The corrected copy should be marked "Debit-Adjust" in the upper right margin, and the copy should be sent to the intermediary. A corrected bill need not be submitted where total inpatient charges are not changed by more than \$10 or the interim cost reimbursement by more than \$1.



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3000 – Definitions

3100 – Coverage of Services

3200 – Deductibles and Coinsurance  
Amounts

3300 – Requirements for Payments





3000 – Definitions

3100 – Coverage of Services

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Amounts

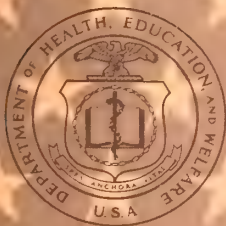
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HEALTH  
INSURANCE  
FOR THE AGED

PART A  
INTERMEDIARY  
MANUAL



U.S. DEPARTMENT OF  
HEALTH, EDUCATION, AND WELFARE  
Social Security Administration

HIM-13 (7-66)

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3000 - Definitions

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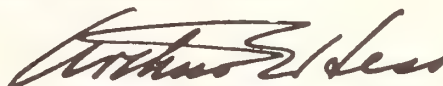
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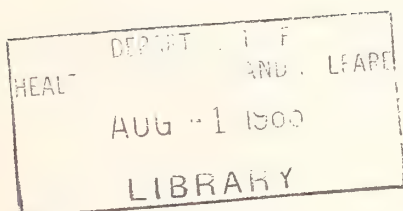
## FOREWORD

This manual is for official use only. It is intended to be used in the administration of the health insurance program by personnel of intermediary organizations. The contents of the manual should not be released. The intermediary may excerpt language concerning provisions of the law in communications with the public, but the manual should not be cited as a reference.

The manual is designed to be revisable to accommodate new pages as further interpretations of the law and changes in procedures are made. Accordingly, revised sections, pages, or chapters will be issued as the need presents itself.



us  
ARTHUR E. HESS, Director  
Bureau of Health Insurance







# PART A INTERMEDIARY MANUAL

## PART 3 - CLAIMS PROCESS

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# CHAPTER I

## DEFINITIONS

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Entitlement

## 3001. HOSPITAL INSURANCE BENEFITS ENTITLEMENT

An individual is automatically entitled to hospital insurance protection beginning with the first day of the month he attains age 65 if he has applied for and been determined to be entitled to monthly social security benefits whether or not he is actually receiving benefit payments. Automatic entitlement also extends to qualified beneficiaries under the Railroad Retirement Act. (For social security purposes, a person attains age 65 on the day before his 65th birthday. Example: If birth date is August 1, attainment date is July 31, and HIB entitlement date is July 1.)

A social security applicant who applies for monthly benefits after he has reached age 65 is entitled to retroactive hospital insurance benefits beginning with the first month in which he had attained age 65 and met all the requirements for monthly benefits, but not for more than 12 months before the month in which he filed his application. No benefits are payable for hospital or home health services rendered before July 1966, and no benefits are payable for extended care services rendered before January 1967.

Entitlement to hospital insurance benefits ends with the month the individual ceases to be entitled to social security monthly benefits or ceases to be a qualified railroad beneficiary (for example, a woman whose wife's benefits are terminated by divorce). A person who ceases to be a social security or railroad retirement beneficiary but who meets the requirements of the special transitional provision described below may reinstate his hospital insurance by filing a proper application under the transitional provision.

In the event that an individual's entitlement to monthly benefits ends because of death, no monthly benefits are payable for that month. However, his hospital insurance continues for the month of his death.

3001.1 Transitional Provision.--A special transitional provision in the law permits persons 65 years of age and over, who lack social security entitlement or railroad retirement qualification, to obtain hospital insurance protection upon filing application. Such an individual must be a resident of the United States and either a citizen or an alien lawfully admitted for permanent residence who has resided in the United States continuously for 5 years. He may not be an active or retired Federal employee who is or could have been covered by the Federal Employees Health Benefit Act of 1959. He may not be a member of a Communist

organization nor have been convicted of a crime against the security of the United States.

To obtain coverage under the transitional provisions, a person attaining age 65 after 1967 must have three quarters of coverage for each year elapsing between 1965 and the year in which he attains age 65.

Hospital insurance protection under the transitional provision can also be retroactive for as many as 12 months before the month of application, provided the individual meets all the other requirements during the period of retroactivity.

### 3003. SUPPLEMENTARY MEDICAL INSURANCE BENEFITS

A. Enrollment.--To obtain supplementary medical insurance coverage an individual must enroll in the plan and pay the required premium. He is eligible to enroll if he is entitled to hospital insurance benefits or is 65 years of age and otherwise meets the requirements for hospital insurance coverage under the transitional provision of the law. Active or retired Federal employees (or their spouses) are eligible to enroll whether or not covered under the Federal Employee's Health Benefit Act. (For social security purposes an individual attains age 65 on the day before his 65th birthday.)

By agreement, States may enroll in the supplementary medical insurance plan eligible individuals who are receiving money payments under certain public assistance programs. Persons entitled to monthly social security or railroad retirement benefits may be included at the option of the State.

B. Enrollment Periods.--Enrollment is possible only during specified enrollment periods.

1. During the initial general enrollment period an opportunity to enroll was afforded to all persons age 65 and otherwise eligible before 3/1/66. This enrollment period ended 5/31/66. (An individual who was eligible to enroll during this period but failed to do so before 6/1/66, may, for good cause, enroll any time before 10/1/66.)

2. For persons who first become eligible on or after 3/1/66, the initial enrollment period is of 7 months' duration. It begins 3 full calendar months before and ends 3 full calendar months after the month in which the individual first meets all the requirements for enrollment.



3. General enrollment periods occur October 1 through December 31 of each odd-numbered year beginning with 1967. These afford enrollment opportunities to those who failed to enroll during their initial enrollment periods and to those whose enrollment has terminated.

4. States which desire to enroll eligible individuals receiving public assistance must request coverage before January 1968, and enter into an agreement with the Government.

An individual who fails to enroll for supplementary medical insurance within the 3-year period after the close of his initial enrollment period is precluded from enrolling in the supplementary medical insurance plan.

An individual whose enrollment has terminated may reenroll only once and this must occur in a general enrollment period which begins within 3 years after the termination of his prior enrollment.

Payment may be made for covered services if the individual was enrolled at the time the services were furnished, even though at the time the request for payment is filed with the intermediary his enrollment had been terminated.

3003.1 Premiums.--Initially the premium is \$3 per month. The law permits the Secretary of Health, Education, and Welfare to adjust the premium amount if medical costs rise. No increase in the premium is permitted before 1968, and increases thereafter can be made not more often than every 2 years. To take into account the higher cost of insuring older individuals, premiums payable by a person who enrolls later than the first enrollment period open to him, or who reenrolls after his initial enrollment was terminated, are increased by 10 percent for each full 12 months he could have been but was not enrolled. A grace period has been provided for payment of premiums. This period extends for 2 months after the month in which the premium is due.

Social security and railroad retirement beneficiaries, and civil service annuitants (except those enrolled by the State as public assistance recipients) who elect to enroll under this plan will have the premium withheld from their monthly checks. The State pays the premium for the public assistance recipients it enrolls including those who are social security or railroad retirement beneficiaries or civil service annuitants. Other enrollees must make premium payments directly to the Social Security Administration. Enrollees who make direct premium payment will generally be billed quarterly. However, State or local government

organizations, employers, unions or other organizations may desire to pay premiums for their members who would otherwise be paying their premiums by direct remittance. If the organization's enrollee-group includes at least 100 members, a single bill for the group may be rendered monthly or quarterly at the election of the organization provided each member of the group has authorized this method of payment.

### 3003.2 Beginning of Coverage

A. Enrollment during the initial general enrollment period--coverage begins 7/1/66. An individual who attained age 65 prior to March 1966, and who, on establishing good cause for failure to enroll timely, enrolls between June 1, 1966, and September 30, 1966, will have coverage beginning the 1st day of the 6th month after the month in which he enrolls.

B. Enrollment during the individual's initial enrollment period--coverage begins:

1. 1st day of the month in which the individual becomes 65, if he enrolls before the month that he becomes 65.
2. 1st day of the month following the month that he becomes 65, if he enrolls in the month that he becomes 65.
3. 1st day of the 2nd month after the month of enrollment, if he enrolls in the month after he became 65.
4. 1st day of the 3rd month after the month of enrollment, if he enrolls more than one month after the month in which he became 65. (However, individuals who become age 65 in March 1966, and enroll in May 1966, will have coverage effective July 1, 1966.)

C. Enrollment during one of the general enrollment periods--coverage begins the following July 1st.

D. Enrollment by a State of its welfare recipients--coverage begins on the latest of the following, but not later than January 1, 1968:

1. July 1, 1966;
2. 1st day of the 3rd month after the month of the agreement with the State;
3. 1st day of the first month in which the individual is



both eligible and a member of the group;

4. the date specified in the agreement.

### 3003.3 Coverage Ends

A. An individual whose medical insurance premiums are being deducted may notify the Administration in writing, during a general enrollment period that he no longer wishes to participate in the supplementary medical insurance plan. In this case his coverage period is terminated effective with the close of the year in which his notice is submitted to the Administration.

B. Enrollment under the supplementary medical insurance plan is terminated because of nonpayment of premiums. Termination of the coverage period is effective as of the end of the grace period (see C. above) provided for payment of his premiums.

C. In the case of an individual enrolled under a Federal-State agreement, his coverage period ends on whichever of the following first occurs:

1. The end of the month in which he becomes ineligible (as determined by the State) for welfare money payments of a kind specified in the agreement; or
2. The end of the month before the first month for which he becomes entitled to monthly social security or railroad retirement benefits, unless the State exercises its option to enroll its welfare recipients who are entitled to such benefits.
3. A social security or railroad retirement beneficiary who was enrolled under a State agreement and thereafter ceases to be a public assistance recipient may terminate his enrollment during the 3-month period after the month he leaves the public assistance rolls.

If an individual's coverage under a Federal-State enrollment agreement is terminated, his coverage continues without interruption if he is a social security or railroad retirement beneficiary or makes other arrangements for continued payment of premiums.

D. An individual will have coverage through the month in which he dies.



Provider and Related Definitions

3005. PARTICIPATING PROVIDERS OF SERVICES

Providers of services are Hospitals, Extended Care Facilities, and Home Health Agencies.

Payment may ordinarily be made only to a participating provider for covered services furnished by the provider or by others under arrangements with the provider. A participating provider is an institution, facility, or agency which has been approved by the Social Security Administration as a provider of services; and has entered into an agreement with the Administration which provides that it will not charge any patient or other person for covered items and services, except deductibles and coinsurance amounts; will return any money incorrectly collected; and will provide services on a nondiscriminatory basis in compliance with Title VI of the Civil Rights Act of 1964.

3007. UNDER ARRANGEMENTS

Arrangements made by a provider with others for the furnishing of items or services must be such that receipt of payment by the provider for the services (whether in its own right or as agent) discharges the liability of the beneficiary or any other person to pay for the services.

The furnishing of items and services under arrangements is subject to additional special requirements depending on the type of provider making the arrangements.

Inpatient hospital services (see §§ 3101.4, 3101.5 and 3101.6).

Outpatient hospital diagnostic services (see § 3111ff.).

Hospital services under medical insurance (see § 3115.2).

Home health services (see § 3025.2).

3008. TERMINATION OF PROVIDER PARTICIPATION

A provider may terminate its agreement with the Administration by providing the Administration and the public with notice of its intention to terminate the agreement. Written notice of the intention to terminate must be filed with the Administration 6 months before the proposed date of termination. The Administration may, however, where it determines it to be appropriate, accept a notice of termination filed less than 6 months before the proposed date of termination.

A provider's agreement may be terminated by the Secretary if it is determined:

A. that the provider is not complying substantially with the provisions of its agreement or with the provisions of the health insurance law or regulations; or

B. that the provider's services no longer substantially meet the legal requirements; or

C. that the provider has failed to provide information which the Secretary finds necessary to determine what payments are or were due or has refused to permit examination of its fiscal records to verify information provided.

3008.1 Effect of Termination on Provider Services.--The termination of an agreement bars the coverage of:

1. inpatient hospital services (including inpatient tuberculosis and psychiatric hospital services) and posthospital extended care furnished to any individual who is admitted to the institution on or after the effective date of termination.

2. home health services furnished under a plan which is established on or after the effective date of termination; or, if the plan was established before the effective date of termination, services furnished under the plan to the individual after the calendar year in which the termination is effective.

3. any other items or services (e.g., outpatient diagnostic services) furnished on or after the effective date of termination.

#### 3010. HOSPITAL DEFINED

A hospital (other than tuberculosis or psychiatric) means an institution which:

A. is primarily engaged in providing, by or under the supervision of physicians to inpatients

1. diagnostic and therapeutic services for medical diagnosis, treatment, and care of injured, disabled, or sick persons; or

2. rehabilitation services for the rehabilitation of injured, disabled, or sick persons

B. maintains clinical records on all patients;

- C. has bylaws in effect with respect to its staff of physicians;
- D. has a requirement that every patient must be under the care of a physician;
- E. provides 24-hour nursing service rendered or supervised by a registered professional nurse, and has a licensed practical nurse or registered professional nurse on duty at all times;
- F. has in effect a hospital utilization review plan;
- G. is licensed or is approved by the State or local licensing agency as meeting the standards established for such licensing;
- H. meets other health and safety requirements found necessary by the Secretary of Health, Education, and Welfare. (These additional requirements may not be higher than comparable ones prescribed for accreditation by the Joint Commission on Accreditation of Hospitals with exceptions specified in the law.)
- I. is not primarily for the care and treatment of mental diseases or tuberculosis.

#### 3012. HOSPITAL FOR EMERGENCY SERVICES

A nonparticipating hospital is one which does not have an agreement in effect with the Secretary whether or not it meets the conditions of participation. Such a hospital, however, may receive payment for inpatient hospital services or outpatient hospital diagnostic services furnished by it, or by others under arrangements with it, under the following conditions:

- A. The services must be emergency services;
- B. They must be covered services under the hospital insurance plan;
- C. The hospital must meet the requirements of the definition of a hospital, psychiatric hospital, or tuberculosis hospital, except those relating to a utilization review plan and the health and safety conditions prescribed by the Secretary; and
- D. It must agree on an individual case basis not to charge any patient or other person for items or services covered by hospital insurance benefits except deductibles and coinsurance amounts; and return any money incorrectly collected.



Payment for emergency inpatient hospital services and outpatient hospital diagnostic services may be made to such nonparticipating hospital to the same extent as payment could be made if a participating agreement were in effect.

**3012.1 Definition of Emergency Services.**--Under the health insurance program, emergency services are those outpatient hospital diagnostic services and inpatient hospital services which are necessary to prevent the death or serious impairment of the health of the individual, and which, because of the threat to the life or health of the individual, necessitates the use of the most accessible hospital available and equipped to furnish such services.

The determination as to whether the services furnished meet the definition of emergency services will ordinarily be based upon the physician's assessment of the apparent condition of the patient at the time of his arrival at the hospital or upon the physician's judgment as to his condition following examination of the patient. When the examination and diagnosis of the patient is undertaken because the apparent condition of the patient is such that failure to do so immediately might threaten his life or result in serious impairment of his health, the services furnished are emergency services. Similarly, when in the judgment of the physician attending the patient at the emergency or accident room, the individual's admission as an inpatient is required to prevent the death or serious impairment of the patient's health, the inpatient services furnished are emergency services.

**3012.2 Termination of Emergency Services.**--Since payment can be made to a nonparticipating hospital only for emergency services, no payment can be made to such an institution for services rendered after the emergency has ceased to exist. An emergency no longer exists when it becomes safe from a medical standpoint to move the patient to a participating institution or to discharge him, whichever occurs first. Since only a physician is in a position to determine when, from a medical standpoint, an individual can be discharged from care or moved to a participating hospital, the responsibility for determining when an emergency ends rests with the physician.

**3012.3 Physician's Supporting Statements.**--Claims filed by a nonparticipating hospital for payment for emergency services must be accompanied by a physician's statement describing the nature of the emergency and certifying that the services rendered

were necessary to prevent the death of the individual or the serious impairment of his health. A bare statement that an emergency existed would not be sufficient. In addition, the statement must include the date when, in the physician's judgment, the emergency ceased. Most emergencies will be of relatively short duration so that only one bill will be submitted in a case. Thus, generally only one physician's statement will be necessary. However, in the rare situation where an emergency exists over an extended period, requests for payment following the initial one must be accompanied by a physician's statement containing sufficient information to clearly indicate that the emergency situation still existed. A bare statement that the emergency continues to exist would not be acceptable.

3013. EMERGENCY INPATIENT HOSPITAL SERVICES FURNISHED OUTSIDE THE UNITED STATES

To be reimbursable, hospital services must ordinarily be furnished within the United States (see § 3150.4 for definition of United States). Payment for emergency inpatient hospital services furnished outside the United States may be made if:

A. The individual was physically present in the U.S. at the time the emergency occurred; and

B. The foreign hospital was closer or substantially more accessible than the nearest hospital within the U.S. which was adequately equipped to deal with, and available for the treatment of the individual's condition; and

C. The foreign hospital makes the agreements regarding payment on a case-by-case basis and meets the other requirements necessary to entitle it to payment for emergency services as a nonparticipating hospital. See §§ 3012 ff.

3015. TUBERCULOSIS HOSPITAL

A Tuberculosis Hospital is an institution which is primarily engaged in providing by or under the supervision of a physician, medical services for the diagnosis and treatment of tuberculosis. To be eligible for participation in the program, it must be accredited by the Joint Commission on Accreditation of Hospitals, have in effect a utilization review plan, and comply with additional staffing and medical record requirements necessary to carry out an active program of treatment and intensive care.

3016. PSYCHIATRIC HOSPITAL

A Psychiatric Hospital is an institution which is primarily engaged



in providing by or under the supervision of a physician, psychiatric services for the diagnosis and treatment of mentally ill persons. To be eligible for participation in the program as a psychiatric hospital, it must be accredited by the Joint Commission on Accreditation of Hospitals, have in effect a utilization review plan, and comply with additional staffing and medical record requirements necessary to carry out an active program of treatment and intensive care.

3017. PART OF A TUBERCULOSIS OR A PSYCHIATRIC INSTITUTION AS A  
TUBERCULOSIS OR PSYCHIATRIC HOSPITAL

A distinct part of a tuberculosis or psychiatric institution can be considered a psychiatric or a tuberculosis hospital if that part meets the conditions of participation even though the institution of which it is part does not; and if the distinct part meets requirements equivalent to the accreditation requirements of the JCAH, it could qualify under the program even though the institution is not accredited. A distinct part of a nonaccredited hospital, where such hospital does not meet the requirement as to licensure or approval, must itself meet such a requirement.

A distinct part of a psychiatric or tuberculosis institution will be considered to meet requirements equivalent to the accreditation requirements of the JCAH if it is found to be in substantial compliance with Hospital Conditions of Participation I through XV.

In addition, a distinct part of such an institution would have to be in substantial compliance with condition XVI, relating to utilization review, and either conditions XVII and XVIII (psychiatric) or conditions XIX and XX (tuberculosis) relating to special medical records and staffing.

A distinct part of a psychiatric or tuberculosis hospital desiring to qualify as a psychiatric or tuberculosis hospital will be deemed to meet JCAH requirements for accreditation if the institution of which it is a part is accredited by JCAH.

There is no provision for a psychiatric or tuberculosis wing of a general hospital to be certified as a psychiatric or tuberculosis hospital "distinct part." The distinct part provisions apply only to psychiatric and tuberculosis institutions and not to general hospitals.

3018. GENERAL HOSPITAL FACILITY OF TUBERCULOSIS OR PSYCHIATRIC  
HOSPITAL

A general hospital facility within a psychiatric or tuberculosis



hospital may be certified as a general hospital independent of the institution as a whole provided the general facility is operated separately from the rest of the institution. The general hospital facility would be regarded as a separate institution for this purpose since the law does not provide for certifying a "distinct part" of an institution as a general hospital. Services furnished in a separately certified general hospital facility would not be subject to any of the benefit limitations applicable to the other part of the institution, i.e., the 90-day carryover in the case of psychiatric and tuberculosis hospitals and the 190-day lifetime maximum in the case of psychiatric hospitals.

#### 3020. EXTENDED CARE FACILITY

An extended care facility is one which provides skilled nursing care and related services for patients who require medical or nursing care; or rehabilitation services for injured, disabled, or sick persons. It may be either a separate institution (such as a nursing home) or a part of an institution (such as a convalescent wing of a hospital). It must be licensed or approved under State or local law, meet the health and safety conditions prescribed by the Secretary, and have a written transfer agreement with one or more participating hospitals providing for the transfer of patients between the hospital and the facility and for the interchange of medical and other information. If an otherwise qualified extended care facility has attempted in good faith, but without success, to enter into a transfer agreement, this requirement may be waived by the State agency. An extended care facility primarily for the care and treatment of mental disease or tuberculosis is excluded.

#### 3023. CHRISTIAN SCIENCE SANATORIUM

A Christian Science sanatorium operated or listed and certified by the First Church of Christ, Scientist, Boston, Massachusetts, may qualify as both a hospital and extended care facility. Extended care in such an institution is, however, subject to special provisions and limitations on the nature, duration, and extent of the services covered.

An individual may elect to treat the services furnished him by a Christian Science sanatorium as sanatorium extended care services. If the individual so elects, the sanatorium services will be considered to be furnished by the sanatorium in its capacity as an extended care facility. Payment for sanatorium extended care services may be made for up to 30 days only in each spell of illness, instead of the 100 days applicable to extended care services generally. This benefit will be available beginning January 1, 1967.

Payment may not be made on behalf of an individual for sanatorium extended care services furnished him after he has been furnished post-hospital extended care services during the same spell of illness as an inpatient of a qualified extended care facility which is not a Christian Science sanatorium. Similarly, payment may not be made for post-hospital extended care services furnished to an inpatient of an extended care facility which is not a Christian Science sanatorium after he has been furnished, during the same spell of illness, covered sanatorium extended care services.

### 3025. DEFINITION OF HOME HEALTH AGENCY

A home health agency is a public agency or private organization, or a subdivision of such an agency or organization, which meets the following requirements:

A. It is primarily engaged in providing skilled nursing services and other therapeutic services, such as physical, speech, or occupational therapy, medical social services, and home health aide services. A public or voluntary nonprofit health agency may qualify by:

1. furnishing both skilled nursing and at least one other therapeutic service directly to patients, or
2. furnishing directly either skilled nursing services or at least one other therapeutic service and having arrangements with another public or voluntary nonprofit agency to furnish the services which it does not provide directly.

A proprietary agency can qualify only by providing directly both skilled nursing services and at least one other therapeutic service.

B. It has policies established by a professional group associated with the agency or organization (including at least one physician and at least one registered professional nurse) to govern the services, and provides for supervision of such services by a physician or a registered professional nurse.

C. It maintains clinical records on all patients.

D. It is licensed in accordance with State or local law or is approved by the State or local licensing agency as meeting the licensing standards (where State or local law provides for the licensing of such agencies or organizations).

E. It meets other conditions found by the Secretary of Health, Education, and Welfare to be necessary for health and safety.



A private organization which is not exempt from Federal income taxation under section 501 of the Internal Revenue Code of 1954 (sometimes referred to as a "proprietary" organization) must be licensed pursuant to State law. If the State has no licensing law for such organizations, a proprietary agency cannot participate in the health insurance program.

For services under hospital insurance, the term "home health agency" does not include any agency or organization which is primarily for the care and treatment of mental disease. There is no such restriction under supplementary medical insurance.

3025.1 Subdivisions of Agencies.--When the subdivision of an agency, such as the home care department of a hospital or the nursing division of a health department, wishes to participate as a home health agency, the subdivision must meet the conditions of participation and must maintain records in such a way that subdivision activities and expenditures attributable to services provided under the health insurance program are identifiable.

3025.2 Arrangements by Home Health Agencies

A. Arrangements made by a home health agency with others to furnish items or services must be such that receipt of payment by the home health agency for the services (whether in its own right or as agent) discharges the liability of the beneficiary or any other person to pay for the services.

Whether the services and items are furnished by the home health agency itself or by another agency under arrangements made by the home health agency, both must agree not to charge the patient for covered services and items and must also agree to return money incorrectly collected.

There are 3 situations in which a home health agency may have arrangements with another health organization or person to provide home health services to patients:

1. Where an agency or organization, in order to be approved to participate in the program, makes arrangements with another agency or organization to provide the nursing or other therapeutic services which it cannot provide directly.

2. Where an agency or organization, which is already approved for participation, makes arrangements with others to provide services it does not provide.



3. Where an agency or organization, which is already approved for participation, makes arrangements with a hospital, extended care facility, or rehabilitation center for services on an outpatient basis because the services involve the use of equipment which cannot be made available to the patient in his place of residence.

B. If an agency's subdivision (acting in its capacity as a home health agency) makes an arrangement with its parent agency for the provision of these items and/or services, there need not be a contract or formal agreement. If, however, the arrangement is made between the home health agency and another provider participating in the health insurance program (hospital, extended care facility, or home health agency), there must be a written statement regarding the services to be provided and the financial arrangements.

C. If the arrangements are with an agency or organization which is not a qualified provider of services, there must be a written contract which includes all of the following:

1. A description of the services to be provided.
2. The duration of the agreement and how frequently it is to be reviewed.
3. A description of how personnel will be supervised.
4. A statement that the contracting organization will provide its services in accordance with the plan of treatment established by the patient's physician in conjunction with the home health agency's staff.
5. A description of the contracting organization's standards for personnel, including qualifications, functions, supervision, and inservice training.
6. A description of the method of determining reasonable costs and reimbursements by the home health agency for the specific services to be provided by the contracting organization.
7. An assurance that the contracting organization will comply with Title VI of the Civil Rights Act.

3025.3 Rehabilitation Centers.--When the services are of such a nature that they cannot be administered at the patient's residence and are administered at a rehabilitation center which is not

participating in the program as a hospital, extended care facility, or home health agency, the rehabilitation center must meet certain standards. The physical plant and equipment of such a rehabilitation center must meet all applicable State and local legal requirements for construction, safety, health, and design, including safety, sanitation and fire regulations, building codes, and ordinances.

Physician Defined

## 3030. PHYSICIAN

Physician means a doctor of medicine or osteopathy (including osteopathic practitioner) legally authorized to practice by a State in which he performs such function or action. A doctor of dental surgery or dental medicine having State authorization to practice is also a defined physician but only with respect to surgery related to the jaw or any structure contiguous to the jaw, or the reduction of any fracture of the jaw or any facial bone. (These services must be such services as may be performed by either a qualified physician or dentist, and exclude routine dental care.)

The services performed by a physician within these definitions are subject to any limitations imposed by the State on the scope of practice.

Spell of Illness

## 3035. SPELL OF ILLNESS DEFINED

A spell of illness is a period of consecutive days that begins with the first day (not included in a previous spell of illness) on which a patient is furnished inpatient hospital or extended care services by a qualified provider in a month for which the patient is entitled to hospital insurance benefits. A qualified provider is a hospital (including a psychiatric or tuberculosis hospital) or extended care facility that has been certified as meeting all the requirements of the definition of such an institution. A hospital which meets the requirements in § 3012 is a qualified hospital for purposes of beginning a spell of illness when it furnishes the patient covered inpatient emergency services. THUS, GENERALLY, THE SPELL OF ILLNESS BEGINS WHEN COVERED INPATIENT SERVICES ARE INITIALLY FURNISHED TO AN ENTITLED INDIVIDUAL.

If a person is in a nonqualified institution on the first day of his entitlement under Part A and is subsequently transferred to a qualified hospital (general, psychiatric or tuberculosis), his spell of illness would begin on admission to the qualified hospital.

The spell of illness ends with the close of a period of 60 consecutive days during which the patient was neither an inpatient of a hospital nor an inpatient of an extended care facility. To determine the 60 consecutive-day period, begin counting with the day following the day on which the individual was discharged. It is important to note that for purposes of continuing a spell of illness the hospital or extended care facility in which the stay occurs need not meet all of the requirements that are necessary for starting a spell of illness.



Inpatient services will prolong the beneficiary's spell of illness if the hospital meets the initial requirement of the definitions in §§ 3010, 3015, and 3016. That is, it is primarily engaged in providing, by or under the supervision of physician(s), to inpatients (1) diagnostic and therapeutic services for medical diagnosis, treatment, and care of injured, disabled, or sick persons, or rehabilitation services for injured, disabled, or sick persons; or, (2) psychiatric services for the diagnosis and treatment of mentally ill persons; or, (3) medical services for the diagnosis and treatment of tuberculosis.

Similarly, inpatient services in an extended care facility will prolong a beneficiary's spell of illness if the facility (including one primarily for the care and treatment of mental diseases or tuberculosis) meets at least the requirement that it is primarily engaged in providing to inpatients skilled nursing care and related services for patients who require medical or nursing care, or rehabilitation services for injured, disabled, or sick persons.

An individual may be discharged from and readmitted to a hospital or extended care facility several times during a spell of illness and still be in the same spell if 60 days have not elapsed between discharge and readmission. The stay need not be for related physical or mental conditions. As long as a person continues to be entitled to hospital insurance, there is no limit to the number of spells of illness he may have.

EXAMPLE 1: X was born 8/9/02. On 7/28/67, X entered a participating general hospital. After he had been in the hospital for 2 weeks X was discharged on 8/11/67. On his doctor's orders X entered a participating nursing home on 8/15/67, and remained there until his discharge on 10/27/67. He had no further inpatient stays in 1967. X's spell of illness began on 8/1/67, the first day of the month he attained age 65 and was entitled to hospital insurance. The spell of illness ended 12/26/67, 60 days after his last discharge.

EXAMPLE 2: Y, over age 65, entered a participating general hospital on 7/28/68 for treatment of a heart condition. He was discharged on 8/11/68. On 8/20/68, Y entered a non-participating nursing home, which provided primarily skilled nursing care and related services. Y remained in this facility until his discharge on 10/27/68. On 12/25/68, Y was again admitted to a participating hospital because of injuries suffered in an accident. He was discharged on 1/13/69, and had no further

inpatient stays in 1969. Y's spell of illness began on 7/28/68. His stay in the nursing home began less than 60 days after his hospital discharge and the spell was continued even though the stay was not covered. The subsequent hospital stay began less than 60 days after the nursing home discharge and continued the spell of illness, although the condition treated was unrelated to his prior stays. The spell ended on 3/14/69.





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Inpatient Hospital Services

## 3101. COVERED INPATIENT HOSPITAL SERVICES

Patients covered under hospital insurance are entitled to have payment made on their behalf on a reasonable cost basis for inpatient hospital services. An inpatient is a person who has been admitted to a hospital for bed occupancy for purposes of receiving inpatient hospital services. A person is considered an inpatient if formally admitted as an inpatient with the expectation that he will remain at least over night and occupy a bed even though it later develops that he can be discharged and does not actually use a hospital bed over night.

(If a patient receives items or services in excess of, or more expensive than, those for which payment can be made, payment will be made only for the reasonable cost of the covered items or services. This provision applies not only to inpatient services but to all hospital services under Parts A and B of the program.)

The following inpatient hospital services (including psychiatric and tuberculosis hospital services) are covered.

3101.1 Bed and Board in a Semiprivate Room.--Hospital insurance will pay for semiprivate accommodations (two, three, or four-bed accommodations) unless a private room is medically necessary.

A. Private rooms (or other accommodations more expensive than semiprivate) will ordinarily be considered medically necessary only when the patient's condition requires him to be isolated for his own health or that of others.

The term isolation can apply to the necessary conditions for the treatment of a number of physical and mental impairments. These include communicable diseases such as tuberculosis, typhoid fever, smallpox, and cholera, which in the judgment of the physician require isolation of the patient for certain periods. Privacy may also be necessary for patients whose symptoms or treatment are likely to alarm or disturb others in the same room.

Payment will also be made for the use of intensive care facilities where medically indicated.

B. When accommodations more expensive than semiprivate are furnished for reasons other than medical necessity, e.g., the patient's comfort, payment by the program will be limited to the cost of semiprivate accommodations. The hospital may not charge the patient more than the difference between the customary charges

for the accommodations furnished and the customary charges for semiprivate accommodations at the most prevalent rate at the time of admission. See C. below for definition of "customary charges."

C. When accommodations less expensive than semiprivate are furnished at the patient's request or for a reason determined to be consistent with the purposes of the health insurance program, payment may be made for the reasonable cost of the accommodations furnished. It is considered to be consistent with the program's purpose to furnish bed and board in less expensive accommodations where semiprivate accommodations are not available. The patient must then be moved to semiprivate accommodations when they become available.

It will not be considered consistent with the purposes of the law to assign a patient ward accommodations on the basis of his social or economic status, his national origin, race, or religion, his entitlement to have payment made under the Health Insurance for the Aged Act, or any other discriminatory reason when the patient has not requested such assignment.

In some cases, a patient may be placed in accommodations less expensive than semiprivate neither at his request nor for a reason consistent with the program's purposes. In determining the payment to be made, the reasonable cost of semiprivate accommodations will be reduced by the difference between the institution's customary charges for semiprivate accommodations at the most prevalent rate at the time of admission and for the accommodations furnished. ("Customary charges" means amounts which the hospital is uniformly charging patients currently for specific services and accommodations, with specified and limited exceptions, e.g., a lower charge as a fringe benefit to employees of a hospital and their close relatives.)

D. Payment may be made to hospitals which have only ward accommodations or only private accommodations on the basis of the reasonable cost of the accommodations furnished.

3101.2 Nursing and Other Services.--Nursing and other related services, use of hospital facilities, and medical social services ordinarily furnished by the hospital for the care and treatment of inpatients.

NOTE: The services of a private-duty nurse or other private-duty attendant are not covered. Private-duty nurses or private-duty attendants are registered professional nurses, licensed practical nurses, or any other trained attendant whose services are rendered to and restricted to a



particular patient pursuant to an arrangement for the provision of such services between that patient and the private-duty nurse or attendant.

3101.3 Drugs, Supplies, Appliances.--Drugs, biologicals, supplies appliances, and equipment for use in the hospital, which are ordinarily furnished by the hospital for the care and treatment of inpatients.

A. Drugs and Biologicals.--Two basic requirements must be met in order for a drug or biological furnished by a hospital to be included as a covered hospital service. The drug or biological must represent a cost to the institution in rendering services to the beneficiary; and the drug or biological must either be included, or approved for inclusion in the U.S. Pharmacopoeia, the National Formulary, the U.S. Homeopathic Pharmacopoeia, or New Drugs or Accepted Dental Remedies (except for those unfavorably evaluated). Those drugs and biologicals approved by the pharmacy and drug therapeutics committee, or equivalent committee, of the medical staff of the hospital furnishing them for use in the hospital are also covered.

1. Drugs Covered by the Drug Compendia.--Coverage will be provided only for those drugs and biologicals included, or approved for inclusion, in the latest official edition of the above compendia. The latest official editions are: (1) U.S. Pharmacopoeia, 17th Revision, official from September 1, 1965, (2) the National Formulary, 12th Edition, official from September 1, 1965, (3) U.S. Homeopathic Pharmacopoeia, 7th Revised Edition, 1964, (4) New Drugs, 1966, and (5) Accepted Dental Remedies, 1966.

There are no plans for an official Government list of drugs and biologicals included, or approved for inclusion, in the compendia named in the Act. The exclusion from coverage of drugs and biologicals unfavorably evaluated in New Drugs and Accepted Dental Remedies will apply to those drugs and biologicals which have been unfavorably evaluated for all medicinal uses. If a drug or biological has been unfavorably evaluated for one or more, but not all, medicinal uses, the exclusion applies only where the drug has been unfavorably evaluated for the medicinal use to which it is being put.

Drugs and biologicals will be considered "approved for inclusion" in any of these drug compendia if approved under the procedure established for that purpose by the professional organization responsible for revision of the compendium.



2. Approval by Pharmacy and Drug Therapeutics Committee.--Drugs and biologicals which are not included, or approved for inclusion, in one of the designated compendia are covered as inpatient hospital services if approved for use in the hospital by a pharmacy and drug therapeutics committee (or an equivalent committee)--that is, a committee of the medical staff which confers with the hospital pharmacist in the formulation of policies pertaining to drugs. Such drugs and biologicals are covered only if the committee develops and maintains a formulary or list of drugs accepted for use in the hospital. The committee need not function exclusively as a pharmacy and drug therapeutics committee but may also carry on other medical staff functions.

Drugs and biologicals will be considered approved for use in the hospital if selected for inclusion in the hospital drug list or formulary under the procedure of the committee established for that purpose. Express approval is required; the fact that a drug or biological has not been specifically determined to be unacceptable for use in the hospital will not constitute approval for use in the hospital.

Drugs and biologicals will be covered if approved for general use in the hospital, or if approved for use by a particular patient or group of patients. If the pharmacy and drug therapeutics committee gives approval for use of an investigational drug in the hospital, the drug will be covered to the extent that its cost is not met by funds provided for research.

3. Combination Drugs.--Covered drugs and biologicals include combination drugs on condition that either the combination itself or all of the therapeutic ingredients of the combination are included, or approved for inclusion, in any of the designated drug compendia. In addition, since any drug or biological approved for use in the hospital by the pharmacy and drug therapeutics committee (or equivalent committee) is covered, any combination drug so approved is also covered.

4. Drugs Specially Ordered for Inpatients.--Covered drugs and biologicals are not limited to those routinely stocked in the pharmacy or drug room from which prescriptions are dispensed. A drug or biological not stocked by the hospital but which the hospital obtains specially for the patient from an outside source would also be covered under the circumstances described in the following paragraph.

Since some small hospitals do not maintain a pharmacy or a drug room from which prescriptions are dispensed, drugs and biologicals are in such cases obtained from an outside source such as a commercial pharmacy, and are generally obtained on an individual need basis. For such drugs and biologicals to be covered, they must represent a cost to the hospital; that is, the hospital rather than the patient must be responsible for making payment for the drug to the party from which it is obtained. Whether a drug is covered under such circumstances depends upon the financial arrangements with respect to the individual transaction; it is not required that the same practice be followed with respect to all of the hospital's patients. For example, the fact that medical vendor payments under a public assistance program for drugs furnished to a hospitalized welfare patient go to the commercial pharmacy rather than the hospital (which in this case does not incur a cost for the drug) does not preclude coverage of the same drugs which are purchased directly by the hospital for the use of other patients who are health insurance beneficiaries.

Although a hospital has a pharmacy and drug therapeutics committee (or equivalent committee) of the medical staff which develops and maintains a list or formulary of drugs accepted for use in the hospital, drugs and biologicals not included in the committee's drug list or formulary may, under certain circumstances, also be covered. If the hospital has a policy which permits drugs that are not included in the drug list or formulary to be furnished to a patient at the special request of a physician, the drug would be covered. However, drugs and biologicals furnished under this special procedure would, in order to be covered, have to be included, or approved for inclusion, in one of the designated drug compendia. (In addition, a combination drug, or all of its therapeutic ingredients, would have to be included, or approved for inclusion, in one of the compendia.)

5. Drugs for Use Outside the Hospital.--Drugs and biologicals furnished by a hospital to an inpatient for use outside the hospital are, in general, not covered as inpatient hospital services. However, in any case in which the drug or biological is provided to an inpatient as part of the overall procedure deemed medically necessary to permit or facilitate the patient's departure from the hospital, and a supply of the drug or biological is required until such time as the patient can provide himself or be provided with an ongoing supply of such drugs or biologicals, the drugs or biologicals would be covered as an inpatient hospital service.

B. Supplies, Appliances, and Equipment.--Supplies, appliances, and equipment used for the care and treatment of the beneficiary



solely during his inpatient stay in the hospital are covered inpatient hospital services. In addition, under certain circumstances, supplies, appliances, and equipment used during the beneficiary's inpatient stay are covered even though they leave the hospital with the patient when he is discharged. However, such coverage is limited to circumstances in which it would be unreasonable or impossible from a medical standpoint to limit the patient's use of the item to the periods during which the individual is an inpatient. Examples of items covered under this rule are cardiac valves and cardiac pacemakers which are permanently installed in or attached to the patient's body while he is an inpatient of the hospital; and items, such as tracheostomy or drainage tubes, which are temporarily installed in or attached to the patient's body while he is receiving care and treatment as an inpatient and which are also necessary to permit or facilitate the patient's release from the hospital.

Supplies, appliances, and equipment furnished to an inpatient for use only outside the hospital would not, in general, be covered as inpatient hospital services. However, a temporary or disposable item provided to an inpatient as part of the overall procedure deemed medically necessary to permit or facilitate the patient's departure from the hospital, that is required until such time as the patient can provide himself or be provided with an ongoing supply of such item would be covered as an inpatient hospital service. In order for supplies, appliances, and equipment to be covered as inpatient hospital services, they must be a medically necessary part of the services rendered to the beneficiary.

3101.4 Other Diagnostic or Therapeutic Items or Services.--Other diagnostic or therapeutic items or services ordinarily furnished inpatients by hospitals or by others under arrangements with hospitals are covered as inpatient hospital services if they are a medically necessary part of the services rendered to a beneficiary. This category of covered services encompasses items and services not otherwise specifically listed as covered inpatient hospital services. With respect to items that leave the hospital with the patient when he is discharged, the rules for determining whether the item is covered are the same as the rules set forth above with respect to supplies, appliances, and equipment. It is not required that the hospital itself furnish "other diagnostic or therapeutic items or services;" they are covered when furnished either by the hospital or by others under arrangements made with them by the hospital.

3101.5 Independent Laboratory Defined.--An independent laboratory is one which is independent both of the attending physician's office and of a hospital which is participating in the program as



a provider of services. A laboratory operating under the direction of a physician who holds himself out to the general public or other physicians as being available primarily for the performance of diagnostic x-ray or other laboratory services for other physicians and a laboratory which is part of a nonparticipating hospital are considered to be independent laboratories. The laboratory which a physician or group of physicians maintains for performing diagnostic tests in connection with his or their own practice or an out-of-hospital laboratory which is operated by or under the supervision of a participating hospital or its organized medical staff would not be considered to be an independent laboratory.

Whether a laboratory operated under a lease arrangement is an independent laboratory depends upon the facts of the particular case. The test is whether it may be found to be operated by or under the supervision of the hospital or its organized medical staff.

3101.6 Independent Laboratory Services Furnished Inpatients Under Arrangements with the Hospital.--Diagnostic x-ray, or anatomical or clinical pathology services furnished to an inpatient by an independent laboratory under arrangements with the hospital are reimbursable under hospital insurance provided the laboratory:

A. is licensed under State or applicable local law or is approved by the appropriate licensing agency; or

B. if there is no State licensure law, is under direct supervision of a pathologist on a full-time or regular part-time basis; or

C. is approved to provide these services for the Supplementary Medical Insurance Program. (See § 3115.2.)

Where a hospital provides diagnostic laboratory services to inpatients under arrangements with an independent laboratory, the cost of the services furnished by the independent laboratory for the hospital's inpatients are reimbursable to the hospital under Part A. There is no physician component to such services even if the laboratory is physician-directed.

3101.7 Services of Intern or Resident-in-Training.--Hospital insurance covers the reasonable cost of the services of an intern or resident-in-training under a teaching program approved by the Council on Medical Education of the American Medical Association or, in the case of an osteopathic hospital, approved by the Committee on Hospitals of the Bureau of Professional Education of the American Osteopathic Association. In the case of services of

an intern or resident-in-training in the field of dentistry in a hospital or osteopathic hospital, the teaching program must have the approval of the Council on Dental Education of the American Dental Association. See § 3115.1.C. for services of interns and residents-in-training as hospital services under medical insurance.

3101.8 Special Limitations on Services in Tuberculosis or Psychiatric Hospitals

A. Inpatient Tuberculosis Hospital Service Restriction.--Payment may be made for only those tuberculosis hospital inpatient services furnished when the patient was receiving treatment which could reasonably be expected to improve his condition or render it non-communicable.

B. Inpatient Psychiatric Hospital Service Restriction.--Payment may be made for only those psychiatric hospital inpatient services furnished when the patient was receiving intensive treatment; or for services which were necessary for a diagnostic study or equivalent services for which admission was required.

Duration of Covered Inpatient Hospital Services

## 3103. INPATIENT HOSPITAL BENEFIT DAYS

A patient having hospital insurance coverage is entitled to have payment made on his behalf for up to 90 days of covered inpatient hospital services in each spell of illness. (For coinsurance provision, see § 3203.)

The number of days of care charged to a beneficiary for inpatient hospital services will always be in units of full days. A day begins at midnight and ends 24 hours later. Hospitals and extended care facilities may use a different definition of day for statistical or other purposes, but, in reporting days of care used by beneficiaries, the midnight-to-midnight method is to be used. With the exception of the day of discharge, a day on any part of which an individual is an inpatient is counted as an inpatient day. In counting inpatient days for reimbursement purposes and in determining the total number of days of inpatient care utilized by the beneficiary, the day of admission is counted, but the day of discharge is not counted. If admission and discharge occur on the same day, the count will be 1 inpatient day.

## 3104. INPATIENT TUBERCULOSIS AND PSYCHIATRIC RESTRICTION

If an individual is in a hospital which meets the definition of tuberculosis or psychiatric hospital on the first day of his entitlement to hospital insurance, the number of inpatient benefit days in his first spell of illness is subject to reduction. The days on which he was an inpatient of a psychiatric or tuberculosis hospital in the 90-day period immediately before the first day of entitlement, must be subtracted from the 90 days of inpatient hospital services for which he would be otherwise eligible in his first spell of illness. Both admission and discharge days in the pre-entitlement period count as inpatient days.

This restriction does not apply to tuberculosis or psychiatric services in a general hospital. (See 3203 for effect on coinsurance provision.)

## 3105. INPATIENT PSYCHIATRIC HOSPITAL SERVICES--LIFETIME LIMITATION

Payment may not be made for more than a total of 190 days of inpatient psychiatric hospital services during the patient's lifetime. For purposes of this limitation admission days but not discharge days count as inpatient days.

The limitation applies only to services furnished in a psychiatric hospital.



The period spent in a psychiatric hospital prior to entitlement does not count against the patient's lifetime limitation, even though pre-entitlement days may have been counted against the 90 days of eligibility in the first spell of illness.

3107. INPATIENT SERVICES COUNTING TOWARD MAXIMUMS

Inpatient hospital (including psychiatric and tuberculosis hospitals) services count toward the maximum number of benefit days payable per spell of illness only if

A. payment for services is made or,

B. payment for services would be made if a request for payment was properly filed and if a physician certified that the services were necessary.

Similarly, inpatient psychiatric hospital services count toward the 190-day lifetime limitation on inpatient psychiatric hospital services only if these conditions are met.

Outpatient Hospital Services

3110. OUTPATIENT HOSPITAL SERVICES--GENERAL

A hospital outpatient is a person who has not been admitted by the hospital as an inpatient and who is not lodged in the hospital while receiving outpatient hospital services. An individual who receives hospital services during the day and is not lodged in a hospital at midnight is classified as an outpatient.

Hospitals provide two distinct types of services to outpatients, namely (1) services that are diagnostic in nature, and (2) other services which aid the physician in the treatment of his patient. The outpatient hospital diagnostic services are covered under Part A. All other hospital services provided on an outpatient basis which are incident to physicians' services rendered to outpatients are covered under Part B. The hospital is reimbursed for both types of services on a reasonable cost basis.

3110.1 Rules for Distinguishing Outpatient Hospital Services.

Outpatient hospital services covered under ~~Parts~~ A and B must be separately identified. However, since a patient may receive services covered under both ~~Parts~~ A and B during a single visit to the outpatient department, questions will arise about how to classify a particular service. If the physician designates services as being for diagnostic purposes and separates them from services that are not diagnostic, the hospital will accept these

designations. Normally, however, the physician does not separate the services and need not be asked to do so. Where such a separation of services is not made, hospital and intermediary personnel should use the following rules in deciding how to allocate costs to Parts A and B:

a. Any diagnostic laboratory test or other identifiable diagnostic test furnished by the hospital (or under arrangements and normally identified as such for billing purposes, will be billed to Part A. Any services which can be billed to Part A under this rule must be so billed.

b. All other clinic services and emergency services (even though they may contain some diagnostic implications but are not normally identified as diagnostic services) will be billed to Part B.

### 3111. DIAGNOSTIC SERVICES

A service may be regarded as "diagnostic" if it is an examination or procedure to which the patient is subjected, or which is performed on materials derived from the patient, to obtain information to aid in the assessment of a medical condition or the identification of a disease. Among these examinations and tests are diagnostic laboratory services such as hematology and chemistry, diagnostic x-rays, isotope studies, EKG's, pulmonary function studies, thyroid function tests, psychological tests and other tests given to determine the nature and severity of an ailment or injury.

When furnished by the hospital, diagnostic services, including the services of nurses and technicians, and the use of supplies and equipment are covered under Part A. Where the hospital makes arrangements with other qualified facilities for diagnostic services, such services are covered under Part A only if they are provided (1) in the hospital (e.g., through lease agreement), or (2) by another facility operated by or under the supervision of the hospital or its medical staff. Where the hospital bills for diagnostic services provided by qualified facilities which do not meet the above requirements, payment can be made to the hospital under Part B subject to the conditions in § 3111.2 below.

3111.1 Types of "Arrangements."--Hospitals currently maintain a variety of relationships with independent laboratories for the purpose of supplementing their own facilities in providing diagnostic laboratory services to their patients. Some hospitals rely routinely on independent laboratories; some obtain their services only occasionally. In some cases, there are detailed written

provisions for medical staff supervision of the work performed in the laboratory; in others, the details of the arrangement may be largely a matter of verbal understanding.

3111.2 Diagnostic Services Obtained from "Independent" Laboratories.--Where a hospital obtains laboratory services for its outpatients under arrangements with an independent laboratory, reimbursement for such services will be made to the hospital on a cost basis under the provisions of Part B. Such laboratory is required to be in substantial compliance with the Conditions for Coverage of Services of Independent Laboratories in order for its services to be covered under Part B.

3111.3 Diagnostic Services Obtained Under Arrangements With Another Hospital's Laboratory.--Diagnostic laboratory services obtained for an outpatient of a hospital under arrangements with the laboratory of another participating hospital are reimbursable to the first hospital on a cost basis under the provisions of Part B; i.e., the services were furnished in a facility not operated by or under the supervision of the first hospital or its organized medical staff.

3112. OTHER OUTPATIENT HOSPITAL SERVICES WHICH AID THE PHYSICIAN  
The services, other than diagnostic services, which hospitals provide on an outpatient basis generally will relate to the services that aid the physician in the treatment of his patients. Such services, which include clinic services and emergency services, are covered under Part B. Special items and services which would be covered when furnished during a visit to the clinic include for example, the services of nurses and technicians, use of emergency room, medical supplies such as gauze, dressings, ointments, splints, braces, and other supplies used by the physician in treating the patient, drugs and biologicals which cannot be self-administered, radiology treatments, and special therapy treatments.

#### Outpatient Hospital Diagnostic Services Under Hospital Insurance

##### 3113. COVERED OUTPATIENT DIAGNOSTIC SERVICES

A patient having hospital insurance coverage is entitled to have payment made for outpatient hospital diagnostic services. (Outpatient diagnostic services are on a 20-day diagnostic study basis and not related to a spell of illness.) These services include:

A. Diagnostic tests and related services to the extent that they would not be excluded if performed on an inpatient basis;



B. Drugs and biologicals necessary for diagnostic study (see § 3101.3 for definition of drugs and biologicals);

C. The services rendered in connection with a diagnostic study by an intern or resident-in-training in an approved teaching program (if not under an approved teaching program, see § 3115.1C);

D. Other services and supplies if customarily furnished to outpatients for purposes of diagnostic studies.

If the beneficiary has coverage only under the medical insurance plan, payment for the diagnostic services can be made under Part B. (See § 3115.2 for Part B diagnostic services.)

3113.1 Outpatient Hospital Diagnostic Study Period.--A diagnostic study is a period of 20 consecutive days beginning with the first day, not included in a previous diagnostic study, on which the patient is furnished outpatient hospital diagnostic services. The diagnostic services furnished during the study must be furnished by or under arrangements made by the same hospital. A subsequent study may not begin in or under arrangements made by the same hospital until the prior study has been completed. However, two or more studies may be conducted concurrently in different hospitals. The study ends after 20 days regardless of the number of days on which diagnostic services were actually furnished. Diagnostic services which continue beyond 20 days are considered to be in a new study period and must be separately billed.

#### Hospital Services Covered Under Supplementary Medical Insurance

##### 3115. COVERED SERVICES

Payment may be made under the supplementary medical insurance plan for the reasonable cost of certain hospital services unless they would otherwise constitute inpatient hospital services, extended care services, or home health services. Items and services furnished by others under arrangements with the hospital must be furnished in accordance with the requirements explained in 3007.

3115.1 Services and supplies (including drugs and biologicals) incident to physicians' services rendered to outpatients of hospitals are covered. (See § 3030 for definition of physician.)

A. Services incident to physicians' services in an outpatient department include the services of a nurse, physical therapist, or occupational therapist assisting the physician and under his supervision.

The reasonable cost of services provided by a physical therapist in a hospital outpatient department are covered as incident to physicians' services when they are a direct extension of a physician's service such as a physical therapist working closely with a psychiatrist or orthopedist. However, when a physician prescribes physical therapy which the patient receives in a different department or clinic and the physician is involved only to the extent of ordering physical therapy, such therapy is not incidental to this physician's personal service and generally would not be covered. For example, an internist treating a stroke patient might make a referral to physical therapy but would not be involved in the specifics of such therapy.

B. Supplies incident to physicians' services are those necessary to the physicians' services in the outpatient department, e.g., surgical supplies, surgical dressings, the use of an emergency room, cast room, and operating room for minor surgery.

Drugs and biologicals administered to outpatients must be of the type which cannot be self-administered. These are generally limited to those administered by injection, including those required on a continuing basis, such as for pernicious anemia, or arthritis. However, if the injection is of the type which is commonly self-administered, such as insulin injections, the drug or biological is excluded unless it is administered to the patient in an emergency situation. (For definition of drugs and biologicals and combination drugs, see 3101.3.) Whole blood administered to outpatients is not subject to the whole blood deductible. (See 3205.)

Payment may not be made for immunization, i.e., vaccination or inoculation against diseases such as smallpox, polio, diphtheria, etc. "Immunization" for this purpose, however, does not include a vaccination or inoculation related to the treatment of a particular injury or direct exposure, e.g., antirabies treatment, tetanus antitoxin or booster vaccine, botulin antitoxin, antivenin sera, or immune globulin.

Prescription and nonprescription drugs and biologicals purchased by or dispensed to a patient are not covered.

C. Services of Interns and Residents.--Services performed by interns and residents--including physicians employed by a hospital and acting in the capacity of an intern or resident--are reimbursable to the hospital on a reasonable cost basis even though the intern or resident is also a licensed physician. Services of interns and residents which are covered under Part B include:

1. The medical and surgical services performed for hospital inpatients by interns and residents who are not under approved teaching programs;

2. The diagnostic medical and surgical services performed in hospital outpatient departments by interns and residents not under an approved teaching program;

3. The medical and surgical services (other than diagnostic services) performed in hospital outpatient departments by interns and residents regardless of whether they are under an approved teaching program;

4. The medical and surgical services performed for extended care facility and home health agency patients by interns and residents (whether or not under an approved program) which are not covered under Part A.

See 3101.7 (inpatient hospital), 3113 (outpatient hospital diagnostic), 3118.6 (home health), 3130.C. (extended care) for description of coverage under Part A of other services which interns and residents-in-training perform.

3115.2 Diagnostic x-ray, laboratory, and other diagnostic tests including materials and services of technicians. Some examples of other diagnostic tests are basal metabolism readings, electroencephalograms, electrocardiograms, respiratory function tests, cardiac evaluations, radioactive uptake, allergy, and prothrombin time tests.

Payment may not be made under the supplementary medical insurance plan for outpatient hospital diagnostic services if such services are reimbursable as outpatient diagnostic services under the hospital insurance plan.

Diagnostic x-ray, or anatomical, or clinical pathology services furnished by an independent laboratory are covered under medical insurance only if the laboratory is either licensed under State or applicable local law or is approved as meeting the requirements for licensing by State or local agency responsible for licensing laboratories. Such laboratories must also meet health and safety requirements prescribed by the Secretary of Health, Education, and



Welfare. See "Conditions for Coverage of Services of Independent Laboratories." § 3101.5 defines "Independent Laboratory."

Diagnostic laboratory services may be furnished under Part B even if not furnished in facilities operated by or under the supervision of the hospital as required for outpatient hospital diagnostic services under Part A. (§ 3111.2)

3115.3 X-ray, radium, and radioactive isotope therapy, including materials and services of technicians.

3115.4 Surgical dressings, and splints, casts, and other devices used for reduction of fractures and dislocations. Surgical

dressings include therapeutic and protective covering for lesions either on the skin or opening to the skin. Splints, casts, etc. include dental splints.

**3115.5 Rental of Durable Medical Equipment.**--Durable medical equipment is equipment which can withstand repeated use. It includes such items as iron lungs, oxygen tents, hospital beds, wheelchairs, and other ambulation devices such as crutches and walkers. It must be for use in the patient's home or in a place used as his home, such as a home for the aged or a relative's home.

**NOTE:** The cost of repairs to durable medical equipment already owned by the patient is also covered.

**3115.6 Ambulance Service.**--An ambulance is a specially designed or equipped automobile or other vehicle for transporting the sick or injured. It must have customary patient care equipment such as a stretcher, clean linens, first aid supplies, oxygen equipment, etc., and it must also have such adequate safety equipment as required by local authorities. The ambulance must be operated by personnel specifically trained for ambulance services who have completed the standard and advanced Red Cross first aid courses, or have equivalent training.

To constitute "ambulance service," transportation in such a vehicle is limited to situations where:

- A. It is required by the beneficiary's condition, and
- B. The patient is transported to the nearest hospital with appropriate facilities or to one in the same locality, from one hospital to another, to the patient's home (or place used as his home), or to an extended care facility, or to a hospital where he had formerly been treated if the hospital is within a reasonable distance, and
- C. Such transportation is not merely for the convenience of the patient.

"Locality," as used in requirement B means the service area in the geographic territory surrounding the institution from which individuals generally come or are expected to come for medical service. In most cases this should also be the area in which the supplier of ambulance service normally operates.

Transportation by ambulance to a hospital, extended care facility, or rehabilitation center to obtain home health services not available to the individual in his home is covered only if the conditions in A, B, and C are met. Such transportation is not covered as a home health service.

If the ambulance is operated by a hospital or other provider, reimbursement for this service is made to the provider on a reasonable cost basis.

3115.7 Prosthetic devices (other than dental) which replace all or part of an internal body organ (including contiguous tissue) and replacements or repairs for such devices. The term "internal body organ" includes the lens of an eye and all or part of an ear or nose. Protheses replacing the lens of an eye would include postsurgical eyeglasses which are customarily used during convalescence from eye surgery, or prosthetic lenses required by the aphakic patient.

3115.8 Leg, arm, back, and neck braces, trusses, and artificial legs, arms, and eyes supplied only on a physician's order. Back braces include, but are not limited to, special corsets, sacroiliac, sacrolumbar and dorsolumbar corsets and belts. Replacements are included if required because of a change in the patient's physical condition. Repairs to and adjustment of such appliances, where necessary, are also included even when the appliance had been in use before the user enrolled in the supplementary medical insurance program.

#### Covered and Noncovered Home Health Services

##### 3118. COVERED HOME HEALTH SERVICES

A patient may be eligible for home health service under both hospital insurance and supplementary medical insurance. All services furnished by a home health agency, whether provided directly by the home health agency or under arrangements with others, must be furnished by qualified personnel. The following items and services when provided by the home health agency, or by others under arrangements with the home health agency, are covered under both programs.

3118.1 Part-Time or Intermittent Nursing Care.--Nursing care is professional nursing service provided by a registered professional nurse preferably a qualified public health nurse, in accordance with a physician's orders, or the practical nursing service provided by a licensed practical or licensed vocational nurse working



under the supervision of a registered professional nurse. (See Conditions of Participation for Home Health Agencies for qualifications required for nurses.)

Part-time or intermittent care is usually service for a few hours a day several times a week. Occasionally, service for a full day may be provided for a short period when, because of unusual circumstances, neither the alternative of part-time care nor hospitalization is feasible.

### 3118.2 Physical, Occupational, and Speech Therapy

A. Physical Therapy.--Physical therapy is service provided in accordance with a physician's orders by or under the supervision of a qualified physical therapist.

A qualified physical therapist is an individual who is licensed or registered by the State when licensure laws are applicable, and meets the following criteria:

1. Graduation from a physical therapy curriculum approved by the American Physical Therapy Association from 1928 to 1936, or by the Council on Medical Education and Hospitals of the American Medical Association from 1936 to 1960, or by the Council on Medical Education of the American Medical Association in collaboration with the American Physical Therapy Association since 1960; or

2. Membership in the American Physical Therapy Association or registration by the American Registry of Physical Therapists; or

3. If the physical therapist was trained outside the United States:

- a. Graduation since 1928 from a physical therapy curriculum approved in a country in which the curriculum was located, and the curriculum must have been in a country in which there is a member organization of the World Confederation for Physical Therapy; and

- b. Membership in a member organization of the World Confederation for Physical Therapy; and

- c. Completion of 1 year's experience under the supervision of an active member of the American Physical Therapy Association; and

- d. Successful completion of a qualifying examination as prescribed by the American Physical Therapy Association.

An individual who graduated from any school before its physical therapy curriculum was approved by the appropriate organization mentioned in 1. above is not a qualified physical therapist unless, of course, he is a member of the American Physical Therapy Association or is registered by the American Registry of Physical Therapists.

B. Speech Therapy.--Speech therapy, that is, ~~service in speech~~ pathology or audiology, is service provided in accordance with a physician's orders and furnished by or under the supervision of a qualified speech therapist.

A qualified Speech Therapist is an individual who is certified by the American Speech and Hearing Association, or who has completed the academic requirements and is in the process of accumulating the necessary supervised work experience required for such certification. (The term "speech therapist" includes a speech pathologist.)

C. Occupational Therapy.--Occupational therapy is service given in accordance with a physician's orders and by or under the supervision of a qualified occupational therapist.

A qualified Occupational Therapist is an individual who is registered by the American Occupational Therapy Association or is a graduate of a program in such therapy approved by the Council on Medical Education of the American Medical Association in collaboration with the American Occupational Therapy Association, and is engaged in the required supervised clinical experience period prerequisite to the registration by the American Occupational Therapy Association.

An Occupational Therapy Assistant is an individual who works under the supervision of a qualified occupational therapist and has successfully completed a training course approved by the American Occupational Therapy Association and is certified by that body as a certified occupational therapy assistant.

3118.3 Medical Social Services.--These services must be under the direction of a physician and must be given by or under the supervision of a qualified medical or psychiatric social worker.

A qualified medical or psychiatric social worker is an individual who is a graduate of a school of social work accredited by the Council on Social Work Education, and who has had social work experience in a hospital, outpatient clinic, medical rehabilitation, or medical care program.

A social work assistant is an individual who works under the supervision of a qualified medical or psychiatric social worker, and has a baccalaureate degree, and has received or is receiving on-the-job training in medical social service tasks and assignments from the agency.

#### 3118.4 Part-Time or Intermittent Services of a Home Health Aide.

The services of a home health aide are directed toward the personal care of a patient and are given in accordance with a physician's orders and under the supervision of a registered professional nurse, or, if appropriate, a physical, speech, or occupational therapist. The assignment of a home health aide to a particular case must be made in accordance with a plan of treatment. The specific personal care services to be provided by the home health aide must be determined by a registered professional nurse, and not by the home health aide.

The duties performed are essentially personal health care for the patient, i.e., helping the patient to bathe, get in and out of bed and exercise, retraining the patient in the necessary household skills, assisting him with medications that ordinarily are self-administered and which have been specifically ordered by a physician, and performing incidental household services which are essential to the patient's health care at home and necessary to prevent or postpone institutionalization. The discussion of "part-time or intermittent" services in 3118.1 above is also applicable to home health aides.

3118.5 Medical Supplies (Except for Drugs and Biologicals) and the Use of Medical Appliances.--Medical supplies are items which are essential to enable the home health agency to carry out effectively in the home the kinds of care which the physician has ordered. Medical supplies include (but are not limited to) gauze, cotton, adhesive bandage, surgical dressings, catheters, surgical gloves, rubbing alcohol, irrigating solutions, intravenous fluids, and oxygen.

Medical appliances are items owned or rented by the home health agency and loaned to the patient to facilitate his treatment and rehabilitation. They include, but are not limited to, such items as bedpans, wheelchairs, crutches, hospital beds, trapeze bars, oxygen tents, intermittent positive pressure machines, and air pressure mattresses.

Drugs and biologicals are excluded from coverage as items or services administered by home health agencies, under either hospital insurance or medical insurance. They may, in certain cases, be covered under medical insurance, when administered by

3800 - Special Provisions Related to Payment  
3500 - Admission and Query Procedures  
3200 - Deductibles and Coinsurance Amounts  
3700 - Premiums  
3300 - Requirements for Payment



a physician as a part of his professional services and are not capable of being self-administered.

3118.6 Services of Interns and Residents.--Home health services include the medical services of interns and residents-in-training under an approved hospital teaching program (if the agency has an affiliation with or is under common control of a hospital providing such medical services). "Approved" means approved by the Council on Medical Education of the American Medical Association, or in the case of an osteopathic hospital, the Committee on Hospitals of the Bureau of Professional Education of the American Osteopathic Association, and, in the case of an intern or resident-in-training in the field of dentistry, approved by the Council on Dental Education of the American Dental Association. Reimbursement is provided under Part B for other services hospital interns and residents furnish to beneficiaries receiving home health services.

3118.7 Outpatient Services.--Outpatient services includes any of the items or services described above which are provided under arrangements on an outpatient basis at a hospital, extended care facility, rehabilitation center, or outpatient department affiliated with a medical school, and (1) which require equipment not readily available at the patient's place of residence or (2) which are furnished while he is at the facility to receive the services described in (1). The hospital, extended care facility, or outpatient department affiliated with a medical school must all be qualified providers of services. However, there are special provisions for the use of the facilities of rehabilitation centers (see § 3025.3). The cost of transporting an individual to a facility cannot be reimbursed.

3120. CONDITIONS FOR COVERAGE FOR HOME HEALTH SERVICES UNDER BOTH HOSPITAL AND MEDICAL INSURANCE

3120.1 Patient Must be Under Care of a Physician.--Items and services must be furnished to an individual who is under the care of a physician. This physician may be the patient's private physician; or, a physician on the staff of the home health agency; or a physician working under an arrangement with the institution which is the patient's residence; or if the agency is hospital-based, a physician on the hospital or agency staff. The attending physician establishes the plan of treatment and also certifies to the necessity for home health services.

3120.2 Services Must be Furnished by Agency.--Items and services must be furnished by a participating home health agency or by others under arrangements made by the agency. (See § 3025.2 for definition of "under arrangements.")

3120.3 Services Must Be Furnished Under A Plan.--Items and services must be furnished under a plan established and periodically reviewed by a physician and which relates the items and services to the patient's condition. A plan is "established" when it is reduced to writing by the physician and is made available to the home health agency which has accepted the patient as a client. The plan must specify the types of services required and should, as far as possible, provide a long-range forecast of likely changes in the patient's condition. It should include diagnosis, when and what nursing services are needed, drugs and medications to be used, diet, activity permitted, rehabilitation, therapy needed, medical social services needed, home health aide services needed, and supplies and appliances needed.

The plan must be signed by the attending physician and incorporated into the agency's permanent record for the patient. Any changes must be made in writing and signed by the physician or by a registered professional nurse on the staff of the agency pursuant to the physician's oral orders. All changes in orders for dangerous drugs and narcotics must be signed by the physician.

The plan must be reviewed by the attending physician, in consultation with agency professional personnel, at such intervals as the severity of the patient's illness requires but at least every two months. Each review of a patient's plan should contain the initials of the physician and show the date performed. The agency's record need not be forwarded to the intermediary for review but will be retained in the agency's file.

When an individual has coverage under both Part A and Part B, home health plans under both Parts should not operate concurrently. For example, a plan of treatment is established after hospitalization for a condition for which the patient was hospitalized, and the patient later requires home health services for a condition unrelated to the previous hospitalization but while the original plan of treatment is still in effect. The original plan of treatment should be modified to take into account the required home health services for the condition not related to previous hospitalization. Otherwise, there would be administrative difficulties in counting home health visits, particularly if two home health agencies became involved. Of course, if the patient does not have Part B coverage, the original plan of treatment cannot be modified to provide home health services not related to prior hospitalization.



When benefits under hospital insurance have been exhausted and a change to benefits under medical insurance is made, it is not necessary for the physician to change the plan of treatment.

3120.4 Services Furnished on a Visiting Basis.--Items and services must be furnished on a visiting basis in the place of residence used as the individual's home. There must be a medical judgment that the patient must be confined for health reasons, and requires home health services on a part-time or intermittent visiting basis, even though the patient may be ambulatory to some extent and may on occasion be able to leave his place of residence with or without aid.

If the services cannot be provided at the patient's residence, because they require equipment which cannot be made available in the patient's home, they may be provided elsewhere (see § 3025.2.A.3. and § 3118.7).

#### 3121. SPECIAL CONDITIONS FOR COVERAGE OF HOME HEALTH SERVICES UNDER HOSPITAL INSURANCE

In addition to the conditions listed in § 3120, the following conditions must be met for coverage under hospital insurance.

3121.1 Time Limitation for Establishment of Plan.--The plan for home health services must be established within 14 days after discharge from a hospital of which the beneficiary was an inpatient for at least 3 consecutive days or, from a covered stay in a participating extended care facility (see § 3020 for definition of extended care facility). It should be noted that for purposes of determining the 14-day period specified in this section the day of discharge is counted as an inpatient day. However, in determining the 3-day period the day of admission but not the day of discharge is counted as an inpatient day. The discharge from the hospital which is required to qualify home health services for payment under hospital insurance must occur after June 30, 1966, and in a month in which the patient has attained age 65. Since the extended care facility discharge must be from a covered stay, it must occur after December 31, 1966.

There must be an actual discharge from a hospital or extended care facility. If, for example, a patient is discharged from an approved care facility to another section of the facility which he uses as his home, he may, if otherwise eligible, receive home health services. If, however, a nursing home approved as an extended care facility has no separate wing or building for use as a place of residence after discharge, the individual will be considered as still an inpatient of the extended care facility and consequently cannot receive home health services.



3121.2 Related Illness or Impairment.--In order for home health services to be covered under hospital insurance, a doctor must certify that the patient needs intermittent nursing care or physical or speech therapy for any condition for which, he was receiving inpatient hospital or extended care services.

3121.3 Transfer of Patient.--If it becomes necessary for the patient to transfer to a different physician or home health agency (in a different locality) after the timely establishment of a physician's plan requirement was met, the original plan may be continued in the new locality if:

A. There is a referral by the patient's physician in the old locality of both the patient and the plan to a physician in the new locality.

B. The patient's physician in the new locality accepts the original plan of treatment and assumes the responsibility of conducting the required periodic reviews of the plan. The plan could, of course, be modified from time to time as determined necessary by the patient's physician in the new locality.

C. A participating home health agency in the new locality accepts the patient.

The number of posthospital home health visits already used in the old locality in the (applicable) year would be taken into account in determining when the limit of 100 visits under the hospital plan is reached.

EXAMPLE: A health insurance beneficiary has received 40 home health visits under Part A when it is decided that his overall recovery would be hastened if he moved to a relative's home in a city 100 miles away. However, the physician who established and is reviewing his home health plan recommends that the physical therapy treatments he has been receiving be continued. A physician in the distant city concurs and agrees to take responsibility for continuance of the plan. When the patient moves, the plan is submitted to a home health agency in the city and services continue as before. The patient is entitled to the remaining 60 home health visits in the applicable year under Part A at his new residence.

3122. SPECIAL CONDITIONS FOR COVERAGE OF HOME HEALTH SERVICES  
UNDER SUPPLEMENTARY MEDICAL INSURANCE

3122.1 Non-Eligibility Under Hospital Insurance.--For home health services to be covered under supplementary medical insurance, the patient must be currently enrolled in the medical insurance plan and, where the home health services to be provided are covered under hospital insurance, not be eligible to receive such services under hospital insurance. Where a patient is eligible for home health services which are covered under both programs, the services are chargeable under hospital insurance. When the benefits payable under hospital insurance are exhausted, he may then utilize the benefits available under the supplementary medical insurance program. A plan covering services under the medical insurance program must be established by the physician, but it may be established at any time.

Prior inpatient care in a hospital or extended care facility is not required for coverage of home health services under the supplementary medical insurance plan.

3122.2 Change to Medical Insurance Home Health Services on Change of Residence.--A patient who changes residence before exhausting his 100 home visits under hospital insurance can receive further home health services only under the medical insurance program if there is no further eligibility for home health services under the hospital insurance plan. This might occur, for example, in the following situations:

A. The physician in the old locality terminates the posthospital home health plan, or

B. There is no physician in the new locality who agrees to accept both the patient and the plan, e.g., the new physician wants to establish an entirely new plan.

For coverage under medical insurance in these circumstances, the new physician must establish a new plan.

See section 3121.3 for conditions under which home health services under hospital insurance may continue in the new locality.

3123. DURATION OF HOME HEALTH SERVICES

Under hospital insurance the patient is entitled to up to 100 visits in the 1-year period following the most recent discharge from a 3-day hospital stay or, if later, in the 1-year period after a discharge from a covered stay in an extended care facility. It is important to note that under hospital insurance, coverage extends to only that



number of visits (100 or less) as are furnished after the beginning of a one spell of illness and before the beginning of the next. Both the "stay" and "timely establishment of plan" requirements must be met in the new spell of illness to provide coverage for a new series of home health visits.

If an individual is released from a hospital and has a timely home health plan established, his subsequent return in the same spell of illness to a hospital for a period of 3 or more days or to a covered stay in a participating extended care facility, extends the 1-year period for his visits, dated from the most recent discharge. The total number of visits available before the next spell of illness begins remains unchanged.

The end of the year for hospital insurance purposes is determined as follows: Count 365 days (366 when February 29 is included) beginning with the later of the following:

- a. The date of discharge after June 30, 1966, from a 3-day stay in any hospital, or
- b. The date of discharge after December 31, 1966, from an extended care facility stay for which posthospital extended care benefits were payable on the patient's behalf.

Under supplementary medical insurance a patient is entitled to 100 visits in a calendar year. Entitlement to visits under supplementary medical insurance is related to the calendar year and is unaffected by the patient's spell(s) of illness. If entitled to services under both hospital insurance and supplementary medical insurance, the visits must first be charged against the hospital insurance.

The end of the year under medical insurance is December 31.

EXAMPLE: 1. Jones is hospitalized on February 10 and discharged on March 15, 1967; he has no other hospital or extended care facility stay in 1967, or 1968. He has 100 home health visits beginning the latter part of March and ending on February 20, 1968. All 100 visits are paid for under hospital insurance since the 1-year period runs from March 15, 1967, the date of the hospital discharge, to March 14, 1968. Although Jones' spell of illness ended on May 14, 1967, 60 days after the hospital discharge, home health eligibility was unaffected since a new spell of illness did not begin subsequently.

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EXAMPLE: 2. Robinson was an inpatient in a hospital four times during the same spell of illness, i.e., there was no period of 60 consecutive days during which he was not hospitalized. He was discharged from the hospital, which meets the requirements to qualify subsequent home health services for payment under hospital insurance, on March 15, 1967, May 14, 1967, July 13, 1967, and September 12, 1967. Each hospital stay was for at least 3 consecutive days except the last one. He had home health visits beginning with May 23, 1967, based on a plan established after his hospital discharge of May 14. The 1-year period for home health services under hospital insurance began May 14, 1967, the date of his most recent discharge (in relation to the first home health visit in the spell of illness) from a hospital after a stay of 3 days; it can end no later than July 13, 1968, 1 year after the latest discharge from a hospital stay of at least 3 consecutive days. Thus, in some situations, the "1-year period" during which an individual may have up to 100 home health visits may in fact exceed a year overall.

EXAMPLE: 3. Smith is hospitalized on February 10 and discharged on March 15. He reenters the hospital on July 4. He had 30 home health visits between March 15 and July 4. Since he had been out of the hospital for more than 60 days after his discharge on March 15, a new spell of illness began on July 4, when he reentered the hospital. Therefore, he is not entitled to any additional home health visits under hospital insurance based on his February-March hospital stay. However, an additional 100 home health visits under hospital insurance may begin based on his hospitalization beginning July 4, if he is confined for at least 3 days. If it is for less than 3 days, he will not qualify for home health visits under hospital insurance in the new spell of illness. However, if he is enrolled in the supplementary medical insurance program he is entitled to an additional 100 visits under Part B through December 31, subject to the deductible provisions.

EXAMPLE: 4. Brown is discharged from a hospital on February 15, 1967, after a 3-day stay. He begins receiving home health visits on February 18, 1967. He has until February 14, 1968, to use his 100 visits under

hospital insurance. In July, however, he receives his 100th visit, exhausting the number of visits to which he is entitled under hospital insurance. Coverage of his home health visits may continue unbroken, if he is enrolled under supplementary medical insurance. In that event, he may receive an additional 100 visits under medical insurance through December. In January 1968, he becomes entitled to an additional 100 visits under supplementary medical insurance for the calendar year of 1968.

### 3124. COUNTING VISITS UNDER THE HOSPITAL AND MEDICAL PLANS

The number of visits are counted in the same manner under both the hospital plan and medical plan.

**3124.1 Visit Defined.**--A visit is a personal contact in the place of residence of a patient made for the purpose of providing a covered service by a health worker on the staff of the home health agency or by others under contract or arrangement with the home health agency; or a visit by a patient on an outpatient basis to a hospital, extended care facility, or rehabilitation center, or outpatient department affiliated with a medical school when arrangements have been made by the home health agency for one or more of the covered services. (See §§ 3025ff.)

**3124.2 Counting Visits.**--If a visit is made simultaneously by two or more persons from the home health agency to provide a single service, for which one person supervises or instructs the other, it is counted as one visit. (See example 1.) If one person visits the patient's home more than once during a day to provide services, each visit is recorded as a separate visit (see example 2). If a visit is made by two or more persons from the home health agency for the purpose of providing separate and distinct types of services, each is recorded--i.e., two or more visits (see example 3). If the patient is taken elsewhere for the service because the service could not be furnished in his residence, one visit is counted for each service he receives (see example 4).

- EXAMPLES:**
1. If an occupational therapist and an occupational therapy assistant visit the patient together to provide therapy and the therapist is there to supervise the assistant, one visit is counted.
  2. If a nurse visits the patient in the morning to dress a wound and later must return to replace a catheter, two visits are counted.
  3. If the therapist visits the patient for treatment



in the morning and the patient is later visited by the assistant for additional treatment, two visits are counted.

4. If an individual is taken to a hospital to receive outpatient therapy that could not be furnished in his own home (e.g., hydrotherapy) and, while at the hospital receives speech therapy and other services, two or more visits would be charged.
5. Many home health agencies provide home health aide services on an hourly basis (ranging from 1 to 8 hours a day). However, in order to allocate visits properly against a patient's maximum allowable visits, home health aide services are to be counted in terms of visits. Thus, regardless of the number of continuous hours a home health aide spends in a patient's home on any given day, one "visit" is counted for each such day. If, in a rare situation, a home health aide visits a patient for an hour or two in the morning, and again for an hour or two in the afternoon, two visits are counted.

Under both hospital insurance and supplementary medical insurance, visits count toward the 100-visit maximums only if payment was made for the visits by the program or, if payment would be made if requested by the patient, and the certification requirements (§§ 3326ff.) were met. Visits by personnel other than those providing covered services are not counted. Salaries of personnel employed by the agency to assist in overall operation of the program (e.g., a nutritionist) may be taken into consideration in computing overhead costs of the agency when claiming reimbursement.

An important item to remember about visits under supplementary medical insurance: Visits provided a patient during the period in which he is incurring sufficient expenses to satisfy the deductible will count toward the 100-visit maximum, even though reimbursement is not possible because the \$50 deductible has not been satisfied.

3125. SPECIFIC EXCLUSIONS FROM COVERAGE AS HOME HEALTH SERVICES  
In addition to the general exclusions from coverage under health insurance listed in §§3150ff., the following are also excluded from coverage as home health services:

A. Services or items which would not be paid for if provided to an inpatient of a hospital, such as private-duty nursing service, or items of comfort which are not necessary for treatment, e.g., television.



B. Meals-on-wheels or similar food service arrangements.

C. Domestic or housekeeping services which are unrelated to patient care.

D. Transportation services, e.g., from place of residence to a facility to receive home health services on an outpatient basis.

3130. COVERAGE OF POSTHOSPITAL EXTENDED CARE SERVICES (TO BE COMPLETED IN GREATER DETAIL LATER)

A. Effective Date for Extended Care Services. Benefits for posthospital extended care services will first be available for services furnished on or after January 1, 1967. In addition, the discharge from the period of hospitalization required to qualify for extended care benefits must occur on or after 7/1/66.

B. Benefit Days. Up to 100 days of extended care services are reimbursable if the individual was a hospital inpatient for at least 3 consecutive days before his discharge and was admitted to the extended care facility within 14 days after the date of the hospital discharge. It should be noted that for purposes of determining the 14-day period specified in this section the day of discharge is counted as an inpatient day. However, in determining the 3-day period the day of admission but not the day of discharge is counted as an inpatient day.

C. Services. The intermediary will reimburse a participating extended care facility for:

1. Nursing care provided by or under the supervision of an RPN.
2. Room and board in connection with nursing care.
3. Physical, occupational, or speech therapy furnished either by the extended care facility or by others under arrangements made with them by the facility.
4. Medical social services.
5. Drugs, biologicals, supplies, appliances, and equipment furnished for use in the extended care facility which are ordinarily furnished by such facility for the care and treatment of inpatients.
6. Medical services provided by an intern or resident-in-training (under an approved teaching program) of a hospital with which the facility has in effect a transfer agreement, and other diagnostic or therapeutic services provided by a hospital with which the facility has such an agreement in effect.

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Reimbursement is provided under Part B for other services hospital interns and residents furnish to patients of an extended care facility.

7. Such other services necessary to the health of the patients as are generally provided by extended care facilities.

Items or services which would not be included as inpatient hospital services if furnished to an inpatient of a hospital are excluded.

#### 3145. PROVIDER-BASED PHYSICIANS' SERVICES

The medical insurance program covers physicians' services rendered to individual beneficiaries in or out of the hospital. The charges of provider-based physicians (e.g., those on salary) including radiologists, anesthesiologists, pathologists, physiatrists, and others for services directed to the medical care of the individual patient must be specially billed either by the physician or by the hospital on his behalf. However billed, reimbursement is made on a reasonable charge basis by the supplementary medical insurance (Part B) intermediary. Thus the charges for physicians' services rendered individual beneficiaries are allocated to the medical insurance program and distinguished from the cost of hospital services payable under either the hospital or medical insurance plan. (See § 3607 for billing by hospitals for these services.)

Provider-based physicians often perform services other than those clearly directed to the medical care of individual patients. These may involve teaching and administrative services, and services that benefit the provider's patients as a group. Such physician services, not directly related to an individual patient, if compensated, must be considered in computing reimbursable provider costs and, as such, will be reflected in amounts payable to the provider for services rendered program beneficiaries. (Detailed information on cost computation is contained in reimbursement principles.)



General Exclusions From Coverage

## 3150. GENERAL EXCLUSIONS

No payment can be made under either the hospital insurance or supplementary medical insurance programs for the following items and services:

3150.1 Items and services which are not reasonable and necessary for the diagnosis or treatment of illness or injury or to improve the functioning of a malformed body member; e.g., payment cannot be made for the rental of a special hospital bed to be used by the patient in his home unless it was a reasonable and necessary part of the patient's treatment. Likewise, such potential personal comfort items and services as massages and heat lamp treatments are not covered unless they contribute meaningfully to the treatment of an illness or injury, or the functioning of a malformed body organ.

3150.2 Items And Services For Which There Is No Legal Obligation To Pay.--This exclusion does not apply if the patient has a legal obligation to pay, or some other person or organization has a legal obligation to pay for or provide the items or services. Thus, allowable benefits for covered items and services would be paid by the program even though the same services were covered by a pre-payment plan. Such a plan might be a health insurance policy. This may be of the type which pays money toward the cost of services or it may be a plan that organizes and maintains its own facilities and professional supporting staff.

Free services are excluded from coverage, e.g., free chest X-rays provided by health organizations. In applying this exclusion the determining factor is that there is no legal obligation to pay for the items or services, and not merely the fact that the patient is not charged because of other considerations.

This exclusion, therefore, does not prohibit program payment for services rendered to:

- A. Members of religious orders who are not charged because of a vow of poverty;
- B. Indigents who are not charged because of their inability to pay;
- C. The patient whose need for services resulted from the act or negligence of another who is or may be legally liable for the patient's medical expenses. The existence of a third person's liability does not affect the patient's obligation to pay for the services he receives;



D. Certain residents of homes for the aged. Coverage of health services furnished to a resident of a home for the aged depends on the arrangements under which the services are provided.

1. The typical relationship between the proprietary or profit-making home and the residents is contractual. The home agrees to furnish or pay for certain services, including health services, in return for certain specified payments by the resident. Other services not specified in the agreement must be paid for by the resident. Thus, payment can be made under the health insurance program for services received by the resident of such a home since the individual or the home has a legal obligation to pay for or provide the services.

2. Nonprofit homes are generally operated by religious or fraternal organizations. While these homes are subsidized to a greater or lesser degree, the resident is ordinarily required to contribute to the cost of his maintenance and health care to the extent that he is able. For example, the resident is usually required to assign to the home assets and/or income at the time of admission. Where this is the case, payment may be made under the program for covered services furnished the resident whether or not his circumstances permitted him to pay anything at all for his care.

However, where all services are furnished by the home on a purely charitable basis (i.e., no payment is accepted from residents regardless of their ability to pay), payment could not be made under the health insurance program for items and services furnished by the home. In this situation, however, payment could be made for services furnished by a source independent of the home if that source customarily charges for such services. Thus, payment could be made for services furnished by an independent hospital to which a resident of the home is sent, or for home health services furnished by an independent agency, or for the services of a physician who is not an employee of the home.

3. Certain union homes accept no payment from residents regardless of their ability to pay. Payment may, nevertheless, be made for services provided by such homes where admission to the home and access to the services is a matter of right for union members who meet the necessary qualifications.

4. Homes for Members of Religious Orders.--Many religious orders maintain homes similar to retirement homes to care for members who become ill or infirm. Since members of the order are under a vow of poverty, there is no charge made by the home for this care. Although these services are furnished in a setting that would not ordinarily be expressed in terms of a legal obligation, the order has an obligation to care for its members who have rendered lifelong services. Thus,

payment may be made for services furnished in these homes, whether they are furnished by the home itself or by independent sources that customarily charge for their services.

3150.3 Items and services which are paid for by a governmental entity other than under the Social Security Act or under a health benefits or insurance plan for employees of the governmental entity. The Secretary of Health, Education, and Welfare may specify other exceptions to this exclusion. The Secretary has approved payment for items and services (otherwise covered) even though provided free, if

A. Furnished in or by participating State or local Government-operated hospitals, including psychiatric and tuberculosis hospitals, where the hospital is a general or special hospital serving the general community;

B. paid for by a State or local governmental entity and furnished an individual as a means of controlling infectious diseases or because of the individual's medical indigence. These services need not be furnished in a hospital. Thus, payment may be made for items and services furnished by a Government-operated home for the aged to the indigent aged of the community. Such items and services would be covered whether supplied directly by the home or purchased by it from independent physicians and hospitals.

3150.4 Items and Services Which Are Not Provided within the United States (except for emergency inpatient hospital services furnished outside the United States under the conditions described in section 3013, and payment on behalf of railroad beneficiaries for covered hospital insurance services furnished in Canadian hospitals.) The United States includes the 50 States, the District of Columbia, the Commonwealth of Puerto Rico, the Virgin Islands, Guam, and American Samoa.

3150.5 Items and Services Which Are Required as a Result of War, or an act of war, occurring after the effective date of the patient's current coverage.

3150.6 Personal Comfort Items.--These are items which do not contribute meaningfully to the treatment of an illness or injury or the functioning of a malformed body member. Charges for special items requested by the patient such as radio, television, telephone, and air conditioner, and beauty and barber services are excluded from coverage. Items such as heat lamp treatments and massages are covered only when ordered by a physician.



3150.7 Routine physical checkups, eyeglasses or eye examinations for the purpose of prescribing, fitting, or changing eyeglasses, hearing aids or related examinations, or immunizations. Routine physical checkups include (a) examinations performed without relationship to treatment or diagnosis of a specific illness, symptom, complaint, or injury, and (b) examinations required by third parties such as insurance companies, business establishments, or Government agencies.

The exclusions apply to eyeglasses or contact lenses, and eye examinations solely for the purpose of prescribing, fitting, or changing eyeglasses or contact lenses for refractive errors. The exclusions do not apply to examinations performed in conjunction with an eye disease such as glaucoma or cataracts, or to post-surgical eyeglasses which are customarily used during convalescence from eye surgery, or to prosthetic lenses required by the aphakic patient. In the last situation, the prosthetic lens is a replacement for an internal body organ--the lens of the eye.

Vaccinations or inoculations are excluded as "immunizations" unless they are directly related to the treatment of an injury or direct exposure such as antirabies treatment, tetanus antitoxin or booster vaccine, botulin antitoxin, antivenin sera, or immune globulin.

3150.8 Orthopedic shoes or other supportive devices for the feet. The exclusion of orthopedic shoes does not apply to such shoes if they are integral parts of leg braces.

3150.9 Custodial Care.--The custodial care exclusion precludes payment for patient care which primarily requires protective services rather than definitive medical and skilled nursing care.

3150.10 Cosmetic Surgery or Expenses Incurred in Connection With Such Surgery.--Cosmetic surgery includes any surgical procedure directed at improving appearance, except when required for the prompt (as soon as medically feasible) repair of accidental injury or for the improvement of the functioning of a malformed body member. For example, this exclusion does not apply to surgery in connection with treatment of severe burns or repair of the face following a serious automobile accident or surgery for therapeutic purposes, which coincidentally also serves some cosmetic purpose.

3150.11 Charges Imposed by Immediate Relatives of the Patient or Members of his Household.--



A. Members of the patient's household means those persons sharing a common abode with the patient as part of a single family unit, including those related by blood or marriage as well as domestic employees and others who live together as part of a single family unit. A mere roomer or boarder is not included.

B. Immediate relative as used in this exclusion means spouse, father, mother, son, daughter, brother or sister--by blood, marriage or adoption. Where a business enterprise imposes the charge, a determination must be made as to whether the firm in fact represents an individual within these relationships. If an individual proprietorship is involved, the proprietor will be considered the individual imposing the charge. A corporation is a separate legal entity which cannot be a member of a household or an immediate relative. Charges imposed by a partnership do not fall within the exclusion unless all of the partners are within the designated relationships to the patient.

3150.12 Items and services in connection with the care, treatment, filling, removal, or replacement of teeth or structures directly supporting the teeth. Payment may be made, however, for (a) surgery related to the jaw or any structure contiguous to the jaw, or (b) the reduction of any fracture of the jaw or any facial bone, including dental splints or other appliances used for this purpose.

3150.13 Items and services to the extent that payment has been made, or can reasonably be expected to be made for items or services under a workmen's compensation law or plan of the United States or a State. Payments made for items and services under the health insurance program are subject to repayment to the appropriate trust fund if notice or information is received that payment has been made for the items and services under a workmen's compensation plan. (See §§ 3407ff.

3150.14 Items and services which the provider is obligated by a law of or because of a contract with the Federal Government to render at public expense.

3150.15 Items and services furnished by a Federal provider of services or other Federal agency except (a) for emergency inpatient hospital services and emergency outpatient hospital diagnostic services furnished by a Federal hospital meeting the requirements of section 3013, or (b) when the Federal provider of services has been determined by the Secretary of Health, Education, and Welfare to be providing services to the public generally as a community institution or agency.

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# CHAPTER III

## DEDUCTIBLES AND COINSURANCE AMOUNTS

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Inpatient Hospital - Deductibles and Coinsurance**3201. INPATIENT HOSPITAL DEDUCTIBLE**

The deductible amount applicable to inpatient hospital services for which the patient is responsible is \$40 in each spell of illness. This amount is subject to change but not before 1969. Each year beginning in 1968, the Secretary will determine the amount of the deductible applicable for succeeding years on the basis of the relationship between the average amount paid per day for inpatient hospital services during the preceding year and the rate for 1966. The figure thus derived will be rounded to the nearest multiple of \$4 (or if it is midway between two multiples of \$4, to the next higher multiple of \$4). The year in which the patient's spell of illness begins determines the deductible amount applicable in his case.

The deductible is satisfied only by charges for covered services. Expenses for covered services count toward the deductible on an incurred rather than paid basis.

If the hospital's customary charges for initial inpatient hospital services rendered a patient during a spell of illness are more than the actual charges to the patient, but neither exceeds the \$40 inpatient hospital deductible, the customary charge will be used in computing the amount of the deductible met. (See 3101.1.C for definition of customary charges.) A reduction in benefit days resulting from confinement in a tuberculosis or psychiatric hospital on and immediately preceding the date of entitlement (see 3104) does not affect the amount of the deductible for which the patient is responsible. The deductible amount remains at \$40.

**3203. COINSURANCE**

The patient is responsible for a coinsurance amount of one-fourth of the inpatient hospital deductible, initially \$10, for each day after the 60th day and through the 90th day of inpatient hospital services furnished during a spell of illness.

Although the pre-entitlement period of hospitalization in a tuberculosis or psychiatric hospital counts in determining the 90-day limit on inpatient hospital services in the initial spell of illness (see § 3104), this pre-entitlement period of hospitalization does not count in determining the 60-day period to which the coinsurance amount does not apply. This period must fall within a spell of illness, and a spell of illness cannot begin until a month in which the individual is entitled to benefits.

Example: An individual has been an inpatient of a tuberculosis hospital for 15 consecutive days prior to July 1, 1966, the date he

became entitled to hospital insurance, and he continues to be hospitalized. Although he was not entitled to benefits during the month of June, the 15 inpatient days in June count toward the 90-day limit on inpatient services for the spell of illness beginning July 1. His responsibility for the \$10 per day coinsurance begins August 30, 1966, which is the 61st day in the spell of illness begun on July 1, 1966. He would then have only 15 days remaining in that spell of illness for which payment could be made for inpatient hospital services, and to which the coinsurance amount would apply.

#### 3205. WHOLE BLOOD DEDUCTIBLE

A. Whole Blood Defined.--For purposes of the whole blood deductible, whole blood is human blood from which none of the liquid or cellular components have been removed. Components of blood such as packed cells, plasma, gamma globulin, etc. are not subject to the whole blood deductible.

B. Deductible.--In each spell of illness, hospital insurance payment to any provider must be reduced by the cost of the first 3 pints of whole blood furnished to the patient. The whole blood deductible applies only to the first 3 pints of blood furnished in any spell of illness, even though more than one provider furnishes blood. The patient may be charged the cost of not more than the first 3 pints of whole blood furnished him during the spell of illness.

The whole blood deductible is in addition to any other applicable deductibles and coinsurance amounts for which the patient is responsible. However, the hospital or other provider cannot charge the patient for the cost of any part of the first 3 pints of blood which is replaced on a pint-for-pint basis. The deductible involves only the cost of the blood itself. The cost of administering, storing, and processing whole blood is not part of the whole blood deductible and is covered by the hospital insurance program whether or not the blood is replaced. If the charge to the patient for whole blood exceeds the cost of the blood furnished, the payment to the hospital is reduced by the amount of the excess charge.

In some instances, a hospital may customarily require replacement of blood in an amount greater than that furnished the patient, e.g., a patient furnished 3 pints of blood may be required to arrange for replacement of 4 pints. A patient may replace blood in accordance with the customary blood replacement policy. However, the hospital may not charge the patient who fails to comply with a request to donate blood beyond that which he was furnished and he replaced on a pint for pint basis.



Hospital Insurance Outpatient Diagnostic Services .  
Deductible and Coinsurance

3207. DEDUCTIBLE FOR OUTPATIENT HOSPITAL DIAGNOSTIC SERVICES

The deductible for outpatient hospital diagnostic services during each diagnostic study is one-half the inpatient hospital deductible (initially \$20). This deductible amount counts as an incurred expense for individuals having Supplementary Medical Insurance Coverage. (See 3215.)

3208. COINSURANCE FOR OUTPATIENT HOSPITAL DIAGNOSTIC SERVICES

After satisfying the deductible, the patient is responsible for a coinsurance amount equal to 20 percent of the lesser of the reasonable or customary charges for the diagnostic services rendered during the diagnostic study.

Coinsurance - Extended Care Services

3210. EXTENDED CARE SERVICES

There is no deductible requirement applicable to posthospital extended care services. However, the beneficiary is responsible for a coinsurance amount equal to one-eighth of the inpatient hospital deductible (initially \$5) for each day after the 20th and through the 100th day of extended care services furnished during a spell of illness.

Supplementary Medical Insurance Incurred Expenses  
Deductible and Coinsurance

3212. SUPPLEMENTARY MEDICAL INSURANCE INCURRED EXPENSES

The supplementary medical insurance plan includes coverage, after application of the deductible, for 80 percent of the expenses incurred in connection with

A. Physician services including surgery, consultation, and home, office and institutional calls. (See § 3030 for definition of "physician.")

Regardless of the actual expenses for physician services incurred in the treatment of mental, psychoneurotic, or personality disorders of persons who are not inpatients of hospitals, the amount of such expenses that can be counted in a calendar year is limited to the lesser of \$312.50 or 62.5 percent of actual expenses. This

limitation is not applicable to provider services furnished in connection with the treatment of mental, psychoneurotic, or personality disorders.

B. Services and supplies furnished incident to a physician's services of the kinds which are commonly furnished in physicians' offices and are commonly either rendered without charge or included in physicians' bills.

C. Home health services for up to 100 visits during a calendar year. (These are in addition to the 100 visits payable under hospital insurance.)

D. Outpatient diagnostic service deductibles imposed under the hospital insurance plan for diagnostic studies furnished during the calendar year.

E. Other medical and health services.

### 3213. DEDUCTIBLE

In each calendar year a deductible of \$50 must be satisfied before payment may be made under the supplementary medical insurance plan. However, expenses incurred in the last 3 months of the previous year which were applied toward the medical insurance deductible for that year, may also be applied against the deductible for the current year. Except to the extent that the prior year's expenses are counted, the deductible is satisfied by the initial medical insurance expenses incurred in the current year. Even though an individual is not eligible for the entire calendar year, i.e., his coverage begins after the first month of the year, he is still subject to the full \$50 deductible.

### 3214. COINSURANCE

After the deductible has been satisfied the program will pay 80 percent of the reasonable costs and charges incurred during the balance of the calendar year. The patient is responsible for a coinsurance amount equal to 20 percent of the reasonable charges for the items and services furnished.

### 3215. OUTPATIENT HOSPITAL DIAGNOSTIC DEDUCTIBLE AS AN INCURRED EXPENSE UNDER THE SUPPLEMENTARY MEDICAL INSURANCE PLAN

The amount of any outpatient hospital diagnostic services deductible(s) incurred by an individual during the calendar year under hospital insurance is included as an incurred expense under supplementary medical insurance. It may be used to help satisfy the medical insurance deductible, and is reimbursable under medical insurance if that



deductible has been satisfied. The outpatient diagnostic deductible is the only exception to the rule that payment for services may not be made under medical insurance if the patient was entitled except for the deductibles and coinsurance to have payment made for those services under hospital insurance.

A hospital need not collect the full amount of the outpatient hospital diagnostic deductible if a patient, who has already satisfied the \$50 deductible, later has an outpatient hospital diagnostic study.

If the hospital has collected a Part A outpatient hospital diagnostic deductible and the intermediary determines from the query reply that the medical insurance deductible has already been met, the intermediary should reimburse the patient for 80 percent of the Part A deductible amount he paid.

#### Home Health Services Deductible and Coinsurance

#### 3225. HOME HEALTH SERVICES DEDUCTIBLE AND COINSURANCE

A. Hospital Insurance.--If the patient is receiving home health services under the Hospital Insurance Program, he is not required to meet any deductible or coinsurance requirements. The home health agency will receive payment under the program for covered services based on the determined reasonable costs.

B. Supplementary Medical Insurance.--Charges (not in excess of the amount customarily charged) for home health services under supplementary medical insurance may be used to satisfy the \$50 calendar year deductible. These services are also subject to the 20 percent coinsurance for which the patient is responsible. (See §§ 3213 and 3214 for description of the supplementary medical insurance deductible and coinsurance.)





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CHAPTER IV  
REQUIREMENTS FOR PAYMENT

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Requests for Payment

## 3301. REQUESTS FOR PAYMENT

Before payment can be made for an inpatient hospital stay, extended care services, outpatient hospital diagnostic study, and other outpatient services, or home health services, a written request for payment signed by the patient, or by another person qualified to do so on his behalf must be filed. For convenience, the request for payment has been made a part of the respective billing forms.

## 3302. EXECUTION OF THE REQUEST

If at all practicable, the request should be signed by the beneficiary.

In certain circumstances, it would be impracticable for an individual to sign the request for payment himself because, when he is admitted to the hospital or extended care facility, or begins outpatient hospital diagnostic or other hospital services, or home health services, he is unconscious, incompetent, in great pain, or otherwise in such a condition that he should not be asked to transact any business. In this situation, his representative payee (i.e., a person designated by the Social Security Administration to receive monthly benefits on the patient's behalf), a relative, legal guardian, or a representative of an institution (other than the provider submitting the bill) usually responsible for his care, or a representative of a Governmental entity providing welfare assistance should, if present at time of admission, or start of services, be asked and permitted to sign on his behalf.

When no request for payment is obtained at the time of admission, or start of services, the provider should attempt to obtain such a request later from the patient or other person described above. If the request cannot be so obtained by the time the provider would ordinarily submit its bill to the intermediary, an authorized official of the hospital, extended care facility, or home health agency may sign the request.

When someone other than the patient signs the request for payment, the signer will submit a brief statement explaining his relationship to the patient and the circumstances which made it impracticable for the patient to sign and this statement will be forwarded by the provider with its billing. The intermediary will generally accept such a statement as representing the true facts of the case in the absence of evidence to the contrary.

The provider should not routinely sign the request on behalf of any patient. If experience reveals an unusual frequency of such provider signed requests from a particular provider, the matter will



be subject to review by the intermediary.

If a fully competent and capable patient refuses to sign the request for payment necessary for the provider to obtain reimbursement for the services it furnished, the provider may charge the patient or other person for covered services.

#### 3304. FILING OF THE REQUEST FOR PAYMENT

The request for payment must be filed with the intermediary, or with the Social Security Administration where the provider deals directly with the Government. It is desirable to have the request signed at the time of admission or start of services or care. The request must be filed prior to or in connection with the first billing for services.

A. A request for payment must be filed in connection with each inpatient hospital admission, even though multiple admissions may occur during the same spell of illness. Only one request for payment has to be filed, however, in connection with each inpatient admission, even though an extended hospital stay occasions multiple billings.

B. For diagnostic studies and other outpatient hospital services a signed request for payment is required with each billing by the hospital.

C. Home health services for purposes of requests for payment are considered continuous and, except as indicated below, require only a single signed request for payment.

A subsequent signed request for payment will be required if:

1. There is an interruption of 60 days or more in home health visits furnished by the same agency, or
2. There is a transfer of the patient's care from one home health agency to another.

#### Certification And Recertification By Physicians For Hospital Services

3310. CERTIFICATION AND RECERTIFICATION BY PHYSICIANS--GENERAL  
Payment may be made for covered hospital services only if a physician certifies to the medical necessity for the services. For services continued over a period of time, a physician must recertify the continued need for the services at specified intervals. Appropriate supporting material may be required. Failure to

obtain the required certification and recertification statements in an individual case will result in the hospital not being eligible to receive payment in that case.

Hospitals will not transmit physician certification and recertification statements to the intermediary, or to the Social Security Administration if the hospital deals directly. The hospital must itself certify, on the appropriate billing form, that the required physician certification and recertification statements have been obtained and are on file. The physician certification and recertification statements will be retained in the hospital's files, where they will be available for verification, if needed.

A hospital must also have available in its files a description of the procedure it adopts on the timing of recertifications--that is, the intervals at which recertifications will be required and whether review of long-stay cases by the utilization review committee will serve as an alternative to recertification by a physician in the case of the third or subsequent recertifications.

### 3311. INPATIENT HOSPITAL SERVICES CERTIFICATION

The inpatient hospital services certification should state the medical necessity for inpatient hospital admission. It will not be necessary to state the reason(s) why hospital admission is necessary.

The certification of the medical necessity for inpatient hospital services must be signed by the admitting physician or a medical staff member with knowledge of the case. The routine admission procedure followed by a physician would not ordinarily of itself be sufficient certification of the medical necessity for hospitalization for purposes of the program.

Certifications must be obtained at the time of admission, or as soon thereafter as is reasonable and practicable. However, the individual hospital determines the method by which certifications are to be obtained and the format of the certification statement. Thus, the medical and administrative staffs of each hospital may adopt the procedure they find most convenient and appropriate.

There is no requirement that the certification be entered on any specific form or handled in any specific way, as long as the approach adopted by the hospital permits the intermediary (or the Social Security Administration where the hospital deals directly with the Government) to determine that the certification requirement is in fact met. The certification could, therefore, be entered or preprinted on a form the physician already has to sign; or a separate certification form could be used.



### 3312. RECERTIFICATION FOR INPATIENT HOSPITAL SERVICES

The recertification statement must meet the following standards: it must contain an adequate written record of the reasons for continued hospitalization, the estimated period of time the patient will need to remain in the hospital, and plans for posthospital care. The recertification statement made by the physician has to meet the content standards unless, for example, all of the required information is included in progress notes, in which case the physician's statement could indicate that the individual's medical record contains the information required by the standards and that continued hospitalization is medically necessary.

Recertifications are to be signed by the attending physician or a medical staff member with knowledge of the case. The hospital determines the form of the written record and the manner of obtaining timely recertifications. Thus, the hospital is able to adopt a procedure for obtaining timely recertifications that suits it best.

Where the requirements for the third or a subsequent recertification are satisfied by review of a stay of extended duration, pursuant to the hospital's utilization review plan, a separate recertification statement is not required. However, it is necessary to satisfy the recertification content standards. It would be sufficient if records of the utilization review committee show that consideration was given to the three items mentioned above--the reasons for continued hospitalization, estimated time the patient will need to remain in the hospital, and plans for posthospital care.

### 3313. TIMING OF RECERTIFICATIONS

The first recertification is required no later than as of the 14th day of hospitalization. A hospital may, at its option, provide for the first recertification to be made earlier, or it may vary the timing of the first recertification within the 14-day period by diagnostic or clinical categories.

A second recertification is required no later than as of the 21st day of hospitalization. Thereafter, subsequent recertifications must be made at intervals established by the utilization review committee (on a case-by-case basis if it so chooses), but in no event may the prescribed interval between recertifications exceed 30 days. The utilization review committee will be reviewing long-stay cases and may be in the best position to decide when subsequent recertifications are needed.

A hospital can, if it wishes, coordinate its physician certifications with the process of review by the utilization review committee of



long-stay cases. At the option of a hospital, review of a stay of extended duration under the hospital's utilization review plan may take the place of the third and any subsequent physician recertifications. (Such review may be the initial review, or a second or subsequent review of an extended-stay case by the utilization review committee.)

Where review of an extended-stay case by the utilization review committee is deemed to take the place of a physician recertification, it would be possible for the recertification to be made later than the specified day, because the review of an extended duration case may be made at any time within the 7-day period following the last day of the period of extended duration defined in the utilization review plan. Such a recertification will be treated as a delayed recertification; however, no explanation for the normal delay is required.

#### 3314. INPATIENT PSYCHIATRIC HOSPITAL SERVICES CERTIFICATION AND RECERTIFICATION

The requirements for physician certification and recertification for inpatient psychiatric hospital services are generally the same as for inpatient hospital services. However, the required content of the certification and recertification statements differs from the content of the statements required for inpatient hospital services.

The certification should state that the inpatient psychiatric hospital admission was medically necessary, for either (1) treatment which could reasonably be expected to improve the patient's condition, or (2) diagnostic study.

The recertification should state (1) that inpatient psychiatric hospital services furnished since the previous certification or recertification were, and continue to be, medically necessary for either (a) treatment which could reasonably be expected to improve the patient's condition, or (b) diagnostic study; and (2) that the hospital records indicate that the services furnished were either intensive treatment services, admission and related services necessary for diagnostic study, or equivalent services.

For convenience, the period covered by the physician's certification and recertification is referred to as a period during which the patient was receiving active treatment. If the patient remains in the hospital but the period of "active treatment" ends (e.g., because the treatment cannot reasonably be expected to improve the patient's condition, or because intensive treatment services are not being furnished), program payment can no longer be made even

though the patient has not yet exhausted his benefits. Where the period of "active treatment" ends, the physician is to indicate the ending date in making his recertification. If "active treatment" thereafter resumes, the physician should indicate, in making his recertification, the date on which it resumed.

### 3315. INPATIENT TUBERCULOSIS HOSPITAL SERVICES CERTIFICATION AND RECERTIFICATION

The requirements for physician certification and recertification for inpatient tuberculosis hospital services are generally the same as for inpatient hospital services. However, the required content of the certification and recertification statements differ from the content of the statements required for inpatient hospital services.

The certification should state that the inpatient tuberculosis hospital admission was medically necessary for treatment which could reasonably be expected either to (1) improve the patient's condition, or (2) render the condition noncommunicable.

The recertification should state (1) that the inpatient tuberculosis hospital services furnished since the previous certification or recertification were, and continue to be, medically necessary for treatment which could reasonably be expected either to (a) improve the patient's condition, or (b) render the condition noncommunicable; and (2) that the hospital records indicate such medical necessity.

For convenience, the period covered by the physician's certification and recertification is referred to as a period during which the patient was receiving active treatment. If the patient remains in the hospital but the period of "active treatment" ends (e.g., because the treatment cannot reasonably be expected to improve the patient's condition), program payment can no longer be made even though the patient has not yet exhausted his benefits. Where the period of "active treatment" ends, the physician is to indicate the ending date in making his recertification. If "active treatment" thereafter resumes, the physician should indicate, in making his recertification, the date on which it resumed.

### 3316. OUTPATIENT HOSPITAL DIAGNOSTIC SERVICES CERTIFICATION

A physician should state that outpatient hospital diagnostic services are required for a diagnostic study.

Certification as to outpatient diagnostic services may be made on the physician's orders, on the copy of the summary prepared at the conclusion of the study that is retained by the hospital, or a special form may be used.



Recertification is not required for outpatient hospital diagnostic services. However, if the diagnostic service extends beyond 20 days, a new certification is required for each study period.

3317. CERTIFICATION FOR HOSPITAL SERVICES COVERED BY THE SUPPLEMENTARY MEDICAL INSURANCE PROGRAM

A physician must certify that the medical and other health services covered by medical insurance which were provided by (or under arrangements made by) the hospital were medically required.

In cases in which the hospital provides ambulance service to transport the patient from the scene of an accident and no physician is involved until the patient reaches the hospital, any physician in the hospital who examines the patient or has knowledge of the case may certify to the medical need for the ambulance service.

This certification requires a brief description of the services and the signature of the physician. It need be made only once for a course of treatment. Where services are provided on a continuing basis, such as a course of radium treatments, the physician's certification may be made at the beginning or end of the course of treatment, or at any other time during the period of treatment.

There is no requirement that the certification be entered on any specific form or handled in any specific way, as long as the approach adopted by the hospital permits the intermediary (or the Social Security Administration where the hospital deals directly with the Government) to determine that the certification requirement is in fact met. The certification could, therefore, be entered or pre-printed on a form the physician already has to sign; or a separate certification form could be used.

3318. DELAYED CERTIFICATIONS AND RECERTIFICATIONS

Hospitals are expected to obtain timely certification and recertification statements. However, delayed certifications and recertifications will be honored where, for example, there has been an oversight or lapse.

In addition to complying with the appropriate content requirements delayed certifications and recertifications must include an explanation for the delay and any medical or other evidence which the hospital considers relevant for purposes of explaining the delay. The hospital will determine the format of delayed certification and recertification statements, and the method by which they are obtained. A delayed certification and recertification may appear in one statement; separate signed statements for each certification and recertification would not be required as they would if timely certification and recertification had been made.



3319. TIMING OF CERTIFICATION AND RECERTIFICATION FOR BENEFICIARY  
ADMITTED BEFORE ENTITLEMENT

If an individual is admitted to a hospital (including a psychiatric or tuberculosis hospital) before he is entitled to hospital insurance benefits (for example, before July 1, 1966, or before he reaches age 65), the following rules are applicable when he does become entitled.

No certification as to the medical necessity for inpatient admission is required. Recertifications are required as of the time they would be required if the patient had been admitted to the hospital on the day he became entitled. For example, if a patient becomes entitled to Part A benefits on July 1, 1966, but was admitted prior to that date, the first recertification is required no later than July 14; the second recertification is required no later than July 21; subsequent recertifications are required at intervals not to exceed 30 days. Similarly, if a patient becomes entitled on September 1, but was admitted prior to that date, the first recertification is required no later than September 14; the second, no later than September 21, and so forth.

Certification And Recertification By Physicians  
For Home Health Services

3326. CONTENT OF THE PHYSICIAN'S CERTIFICATION

Under both the hospital insurance and the supplementary medical insurance programs, no payment can be made for covered home health services unless a physician certifies that:

A. the home health services are or were required because the individual is or was confined to his home (except when receiving outpatient services);

B. the individual needed skilled nursing care on an intermittent basis or needed physical or speech therapy;

C. a plan for furnishing such services to the individual has been established and is periodically reviewed by a physician; and

D. the services are or were furnished while the individual was under the care of a physician.

In addition, for services received under hospital insurance, the physician must also certify that services were needed to treat any of the conditions for which the beneficiary received inpatient hospital or posthospital extended care services during the related

hospital or extended care facility stay. Where services are provided under supplementary medical insurance, it is not necessary to relate the need for these services to a period of prior hospitalization or a stay in an extended care facility.

Since the certification is closely associated with the plan of treatment, the same physician who establishes the plan must also certify to the necessity for home health services. Certifications must be obtained at the time the plan of treatment is established or as soon thereafter as possible.

#### 3327. METHOD AND DISPOSITION OF CERTIFICATIONS

There is no requirement that the certification, or recertification discussed below, be entered on any specific form or handled in any specific way, as long as the intermediary can determine, where necessary, that the certification and recertification requirements are met. The certification by the physician will be retained by the home health agency, but the agency must certify on the billing form that the requisite certification and recertifications have been made by the physician and are on file in the agency when it forwards the request for reimbursement to the intermediary.

#### 3328. RECERTIFICATION

Under both the hospital insurance and supplementary medical insurance programs, when services are continued for a period of time, the physician must recertify at intervals of at least once every 2 months that there is a continuing need for services and should estimate how long services will be needed. The recertification should be obtained at the time the plan of treatment is reviewed since the same interval (at least once every two months) is required for the review of the plan. Recertifications must be signed by the physician who reviews the plan of treatment. The form of the recertification and the manner of obtaining timely recertifications is up to the individual agency.

#### 3329. DELAYED CERTIFICATION

The home health agency should obtain certifications and recertifications as promptly as possible. Payment will not be made unless the necessary certifications have been secured. In addition to complying with the usual content requirements, delayed certifications and recertifications must include an explanation for the delay and any other evidence the agency considers necessary in the case. The format of delayed certifications and recertifications and the method by which they are obtained, will be left to the agency.

Tuberculosis and Psychiatric Hospital Records

## 3333. TUBERCULOSIS AND PSYCHIATRIC HOSPITAL RECORDS

The law requires that psychiatric and tuberculosis hospital records contain certain specific information concerning the individual patient's condition and the nature of the treatment provided.

3333.1 In the case of inpatient psychiatric hospital services the hospital records must show that the services were furnished to the patient during periods when he was receiving intensive treatment services, admission and related services necessary for a diagnostic study, or equivalent services. As noted in § 3314, the physician recertification for inpatient psychiatric hospital services must include a statement that the hospital records so indicate.

3333.2 In the case of inpatient tuberculosis hospital services the hospital records must show that the services were furnished to the patient during periods when he was receiving treatment which could reasonably be expected to improve his condition or render it non-communicable. As noted in § 3315, the physician recertification for inpatient tuberculosis hospital services must include a statement that the hospital records so indicate.



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## CHAPTER V

### SPECIAL PROVISIONS RELATED TO PAYMENT

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## 3401. REFUNDS

In its agreement for participation the provider has agreed not to charge for items or services for which an individual is entitled to have payment made on his behalf, and to make adequate provision for return (or other disposition) of any moneys incorrectly collected from an individual (or any other person on his behalf).

A. Moneys incorrectly collected means amounts in excess of the deductible or coinsurance, if applicable, paid to a provider of services by an individual (or other person on his behalf) as payment for covered items and services for which the individual is entitled to have payment made under the health insurance program.

B. The cause of an incorrect collection may be a simple error on the part of a provider in billing a beneficiary for a covered item or service. An incorrect collection may also arise in a retro-active entitlement case in which the beneficiary has paid for covered services to which he later becomes entitled under health insurance. A claim for payment under the guarantee provision may also involve sums incorrectly collected.

Where the intermediary knows that a provider has overcollected deductible and coinsurance amounts for outpatient hospital services or Part B home health services, the intermediary will make direct refund to the beneficiary. (See the bill review instructions in § 3640 and 3650.)

3401.1 Return or Other Disposition of Moneys Incorrectly Collected.

A provider of services in possession of any incorrect collection is required to refund or set aside the money. Until such time as the provider returns or sets aside the incorrectly collected funds, the intermediary shall withhold payment of the reasonable costs of the items and services furnished by the provider.

A. Refund.--Refund is to be made to the beneficiary (or any other person) from whom the provider collected the moneys. If the beneficiary, or other person, cannot be located after reasonable effort on the provider's behalf (including an attempt at contact, by mail, at the last known address), the provider is to request the intermediary to have the Administration records checked in an effort to learn the individual's address. If the individual to whom refund is to be made still cannot be located, or is determined to have died, the provider is to make disposition of the moneys in accordance with the law of the State in which the provider is situated.

B. Moneys set aside.--In some situations refund may be delayed for a prolonged period, (for example, where the beneficiary's whereabouts is unknown or where there is a delay in the appointment of a legal representative to dispose of the estate of a deceased individual). When such a delay in making refund is foreseen, the provider of services will so notify the intermediary and will then set the funds aside in a separate account identified by the name of the individual to whom the payment is due. These amounts will be carried on the provider's records in this manner until final disposition can be made in accordance with the applicable State law.

C. Appropriate time limits within which provider action must be taken.--Sums incorrectly collected should be refunded as promptly as possible. In any event, disposition by refund or by setting aside the funds in a separate account should be accomplished within a period of 60 days after the provider is placed on notice that an incorrect collection was made. The intermediary, in discharging its administrative functions, should attempt through discussion with the provider to effect timely disposition of sums incorrectly collected. Where there is a continued or recurring failure to refund or otherwise dispose of incorrectly collected funds, the Administration may in an extreme case terminate the provider agreement.

#### 3405. GUARANTEE OF PAYMENT PROVISIONS

A hospital may be paid, under certain conditions, for inpatient hospital services furnished to a beneficiary whose eligibility for inpatient hospital benefit days in a spell of illness has been exhausted. The guarantee also extends to inpatient psychiatric hospital services furnished to an individual who has used up his 190-day lifetime limitation on such services. The provision assures at the time of admission that payment will be made to a hospital for its services during the time it takes to notify the hospital of the patient's utilization record. The guarantee includes not only cases in which it turns out that benefits were already exhausted prior to admission, but cases where a beneficiary had some inpatient hospital benefits remaining at the time of his admittance to a hospital, e.g., 2 or 3 days of remaining eligibility, but these benefits are exhausted before the intermediary's reply to the notice of admission reaches the hospital. The guarantee applies only to inpatient hospital services and not to other benefits provided under the hospital or medical insurance programs. A hospital is not required to claim payments under this provision; it may look to the patient for payment.



3405.1 Requirements for Payment Under the Guarantee.-- The following conditions must exist for a hospital to receive payments under this provision (see § 3608 for additional information):

- a. The services provided by the hospital must be covered for inpatient hospital purposes.
- b. The hospital must have acted in good faith in assuming that the individual was entitled to inpatient hospital benefits. There would be an absence of good faith if the hospital had, or should have had, a substantial doubt that coverage existed.
- c. There must have been reasonable grounds for the hospital's assumption that entitlement to benefits existed.
- d. The hospital must agree to refund any payment received from the patient, or on his behalf, for the covered services furnished.

With its bill, the hospital will submit an explanatory statement describing the circumstances which led it to believe that the patient had remaining days of eligibility. If the information is not furnished with the bill, the intermediary will request it.

3405.2 Maximum Number of Days Under Guarantee.--The intermediary (or the Social Security Administration) may pay the hospital for inpatient hospital services furnished for up to 6 days after the day of admission. Saturdays, Sundays, legal Federal holidays, and the first calendar day of admittance to the hospital will be omitted in computing the 6 elapsed days. However, no payment is made for any day after the day the hospital receives a notice of lack of entitlement. The notice may be furnished by mail, messenger, wire, or telephone. If notice is given by telephone, a confirmation in writing will be furnished to the hospital; the date of the telephone message will be considered the date of notification.

In determining the days covered by the guarantee, legal Federal holidays are:

New Year's Day  
Washington's Birthday  
Memorial (Decoration) Day  
Independence Day  
Labor Day  
Veterans Day  
Thanksgiving Day  
Christmas Day

Exclusion of Federal nonworking days prolongs the period covered by the guarantee. When a Federal holiday occurs on a Sunday, the day following is observed as a Federal nonworkday and, therefore, would not be counted as an elapsed day. When the holiday falls on Saturday, the prior Friday would not be counted as an elapsed day. The hospital will be paid on behalf of the beneficiary for all the days of in-patient services within the guarantee period; i.e., weekends, holidays, and the day of admittance will be included in computing the benefit amount due the hospital.

3405.3 Recovery of Funds Advanced Under Guarantee Provision.--  
Benefits paid to hospitals under the guarantee provisions are subject to recovery from the cash benefits to which a beneficiary is entitled under the Social Security or Railroad Retirement Act. Such benefits may be suspended or reduced until the amount advanced to the hospital has been repaid, unless recovery is waived.

Workmen's Compensation

## 3407. GENERAL INFORMATION

Payment under the Health Insurance for the Aged Act is excluded for any items and services to the extent that payment has been made or can reasonably be expected to be made under a workmen's compensation law or plan of the United States or a State. This exclusion is applicable to the workmen's compensation plans of the 50 States, the District of Columbia, and Puerto Rico, as well as the systems provided under the Federal Employees Compensation Act and the Longshoremen's and Harbor Workers' Compensation Act.

The Act requires that any health insurance payment for items or services is to be conditioned on reimbursement to the hospital or supplementary medical insurance trust fund when notice or other information is received that payment for such item or service has been made under workmen's compensation.

The individual is responsible for taking whatever action is necessary to obtain payment under workmen's compensation where payment under that system can reasonably be expected. Failure to take proper and timely action under such circumstances will preclude payment under the health insurance program to the extent that payment could reasonably have been expected to be made under workmen's compensation had the individual exhausted his benefit rights under that system.

## 3408. EFFECT OF PAYMENTS UNDER A WORKMEN'S COMPENSATION PLAN

3408.1 Spell of Illness.--Where an individual receives inpatient services for which payment would otherwise be made under hospital insurance, a spell of illness begins on the first day he receives such services, even though they are completely paid for under a workmen's compensation plan.

3408.2 Benefit Limitations.--In most instances, where an injury or illness is covered under a workmen's compensation plan, that plan will pay all hospital and medical expenses. Where this is the case, the services so paid for in full will not reduce the benefits to which the individual is entitled under health insurance. Thus, services paid for by workmen's compensation will not be counted against the individual's entitlement to 90 days of inpatient hospital services or 100 days of extended care services. Nor would such services count against the 190-day lifetime limitation on inpatient psychiatric hospital services; the 100 home health visits to which the beneficiary is entitled under Part A



and B or the number of full-service days to which he is entitled before the inpatient hospital coinsurance becomes applicable.

Certain plans, however, specify limits on the number of days of care for which payment will be made or the total amount that can be paid for medical attention under workmen's compensation. Services provided after these limits have been reached may be paid for under health insurance, and the days of service or home health visits so paid for would count against the individual's benefit entitlement under health insurance.

3408.3 Deductibles and Coinsurance.--Payments made under workmen's compensation cannot be counted toward the deductibles or coinsurance amounts required under health insurance. Thus, for example, if an individual is hospitalized twice in the same spell of illness and the first hospitalization is completely paid for under workmen's compensation, the inpatient hospital deductible would apply to the second hospitalization. In the same way, medical expenses otherwise reimbursable under Part B, must first be reduced by any workmen's compensation payment before applying the deductible and coinsurance.

3409. GENERAL PROCEDURES IN HANDLING WORKMEN'S COMPENSATION CASES Each intermediary should use its own experience in formulating procedures for handling and control of cases involving workmen's compensation. Procedures must necessarily be adapted to the varying requirements of the laws of the several jurisdictions. However, the following general guidelines are furnished.

There are various indications that an injury or a disease may be work-related. An admission or start of care notice may so specify and, if so, the provider should furnish the name and address of the beneficiary's employer. The nature and circumstances of the injury or disease may suggest that it is work-related. Providers of services have been asked to send the intermediary, with the admission or start of care notice, any information available concerning prior workmen's compensation payments made on behalf of the beneficiary, since the probability exists that the subsequent care for the same injury or disease will also be compensable under workmen's compensation. Such information will enable the intermediary to establish a record of the pending case and to initiate any necessary investigation or development to resolve the issue of workmen's compensation without waiting for the provider's bill.

3409.1 Intermediary's Investigation.--The intermediary's investigation should be carried out as promptly as possible since

a delayed determination by the intermediary that workmen's compensation payments can reasonably be expected coupled with a failure by the patient to file under that system, may result in his loss of benefits under both workmen's compensation and the health insurance program.

Upon receipt of an indication that a work-related injury or disease may be involved, the intermediary should undertake the investigation and development necessary to support its determination. It may utilize its usual investigative methods and procedures and may seek information from the beneficiary, his employer, providers of services, medical insurance carriers, other intermediaries, the workmen's compensation carrier, or the State workmen's compensation agency.

Although the intermediary will often be the first on notice of possible workmen's compensation involvement in a claim, it should coordinate its investigation and determination regarding reasonable expectation of workmen's compensation payment with any carrier(s) or other intermediary(ies) known to be concerned with the claim. It is important that there be consistency in the determinations of intermediaries and carriers concerning the implications of workmen's compensation as related to the same injury or illness.

### 3409.2 Intermediary's Determination and Related Procedures

A. Workmen's Compensation Has Been or Is Being Paid.--If at the time the patient's bill is submitted, workmen's compensation payment has been or is being made which fully covers the cost of the items and services furnished, no payment under the health insurance program may be made.

Where payment under workmen's compensation is less than that which could reasonably be expected under that system, payment under health insurance would be offset to the extent of workmen's compensation payment reasonably expected and not simply to the extent of the actual payment made under that system.

Where a lump sum compromise is awarded as payment of a workmen's compensation claim, the amount of payment for hospital and medical expenses may or may not be specified in such a settlement. However, it is not necessary to examine the settlement to determine the items or services for which payment has been made since the only consideration is the benefits which could reasonably have been expected had the individual pursued his right to payment for medical services under workmen's compensation.



Thus, in those States where there is no limitation on workmen's compensation payment for hospital and medical expenses, no payment could be made under the health insurance program for services required by a work-related injury or disease where a lump sum compromise has been effected.

The provider should be advised in writing of the intermediary's decision and a copy should be sent to the individual. The intermediary should document the case file with the facts bearing on its decision.

NOTE: Even though workmen's compensation payment has been or probably will be made, providers have been asked to submit bills for covered services in the usual manner to the intermediary or to the Social Security Administration if the provider is dealing directly with the Government.

B. Workmen's Compensation is Reasonably Expected.--If at the time the provider submits its bill, workmen's compensation has not been or is not being paid, the intermediary must make a determination as to whether workmen's compensation payment can reasonably be expected and, if so, it must determine the amount reasonably expected.

Should the intermediary determine that there is a reasonable expectation that a workmen's compensation payment will be made for the patient's care, the provider should be notified that health insurance payments are precluded due to the expectation of workmen's compensation coverage. The provider should also be advised that the case may be reopened in the event workmen's compensation does not pay. The individual should also be notified of the intermediary's decision. If the individual has not yet filed a claim under workmen's compensation, the intermediary should advise him to file such a claim and inform him that failure to pursue his claim under workmen's compensation will preclude payment under health insurance to the extent that payment could reasonably have been expected had he done so.

The intermediary should document the file with the facts which were considered in making its determination.

C. Workmen's Compensation is Questionable.--Should the intermediary determine that workmen's compensation payments cannot reasonably be expected, payment under health insurance may be made to the provider on condition that such payment will be refunded in the event workmen's compensation later pays for



the services. However, such conditional payment should not be made unless there is a real question as to whether payment will be made by workmen's compensation. The mere fact that the employer or workmen's compensation carrier is contesting liability would not in itself be a sufficient basis for making payment under health insurance if investigation indicates that the individual can reasonably expect workmen's compensation payment if he pursues his claim.

#### 3411. OVERPAYMENTS

When information is received that workmen's compensation payments have been made subsequent to the payment of health insurance benefits for the same items and services, the intermediary should notify the provider that it has been overpaid. Overpayments to providers may be recouped from providers by direct refund or adjustment of future program payments due the provider.

### Utilization Review

#### 3420. UTILIZATION REVIEW PLAN

Hospitals (including tuberculosis hospitals and psychiatric hospitals) and extended care facilities are required to have in effect a plan for utilization review which applies, at least, to the inpatient services furnished to patients entitled to benefits under the program. The plan must provide for review, on a sample basis, of admissions, duration of stays, and professional services furnished; and review of each case of continuous extended duration during the patient's confinement. Further details on the requirements for an acceptable utilization review plan and guidelines for effectively meeting these requirements are given in section XVI of the "Conditions of Participation; Hospital," and in section XVIII of the "Conditions of Participation for Extended Care Facilities."

The law requires that effective utilization review be maintained on a continuing basis to assure the medical necessity of the services for which the program pays and promote the most efficient use of available health facilities and services.

#### 3421. LIMITATIONS ON PAYMENT

In connection with the utilization review requirement, certain limitations on payment for inpatient hospital services and post-hospital extended care services have been established. (For purposes of this section "inpatient hospital services" include inpatient hospital services and inpatient psychiatric hospital services.)

A. If the physician members of the utilization review committee decide, after opportunity for consultation is given the attending physician, that further inpatient stay is not medically necessary, notification in writing is given within 48 hours to the institution, the patient, and the patient's attending physician. Payment may not be made for more than 3 days of inpatient hospital services or extended care services following the date the notice is received by the institution.

In the event of such a finding, the provider is required to show the date of receipt of the notice on the billing form. Action will be taken as follows:

1. If the discharge date is 4 days or less after the date of receipt of notice, payment may be made for the number of days billed.

2. If the discharge is more than 4 days after the date of receipt of notice, payment for services will be restricted to 3 days after the date of receipt of notice.

B. If the Social Security Administration determines that a hospital or extended care facility has substantially failed to make timely review of long-stay cases, it may, in lieu of terminating the agreement with the provider, decide that no payment may be made on behalf of patients for more than a continuous period of 20 days of inpatient hospital services or a continuous period of 20 days of post-hospital extended care services. The Administration will determine the effective date of this limitation, which will be applicable to services rendered to individuals admitted after that date. The decision may be made effective only after notice is given to the hospital or extended care facility and to the hospital(s) with which the extended care facility has transfer agreement(s), and to the public.

The Social Security Administration will notify the intermediary of the identity of any hospital or extended care facility subject to this limitation and of the effective date of the Administration's decision.

The limitation will be removed when the Administration determines that timely review of long-stay cases has been restored and there is reasonable assurance that the deficiency will not recur.

3800 - Claims Records

3500 - Admission and Query Procedures

3600 - Bill Review

3700 - Procedures





## CHAPTER VI

### ADMISSION AND QUERY PROCEDURES

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## ADMISSION AND QUERY PROCEDURES

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## 3501. THE NOTICE OF ADMISSION OR START OF CARE--DESCRIPTION

When a patient age 65 years or over is admitted to a participating hospital or an extended care facility (ECF), information is obtained from the patient to find out if he is or may be entitled to hospital insurance benefits. After deciding that the patient may be entitled, the hospital or ECF will notify its intermediary of the admission so that the notice can be transmitted to Social Security Administration central records. In cases of a participating Home Health Agency (HHA), a start of care notice is initiated and transmitted under the same circumstances. (See §§3540ff for start of care notice procedures.)

Where only outpatient hospital services are furnished, the hospital will not submit an admission notice. The identifying information that was obtained at the start of outpatient services will be submitted at the same time as the billing information when payment for the services is claimed. The provider will submit a billing form involving only Part A outpatient services at the end of the 20-day study period, or earlier if the diagnostic services ended before the end of the period. The billing for Part B outpatient services only or for Part B outpatient services in conjunction with Part A outpatient diagnostic services will be submitted as soon as the services are completed. (See § 3525 on outpatient queries for Part B deductible status.)

To assure a reply to the admission notice, the intermediary that transmitted it will process a followup with SSA central records after 7 days have elapsed from the date on which it was sent to SSA. Exclude Saturdays, Sundays, and legal Federal holidays (see § 3404) in counting days for the 7-day followup.

The notice of admission or start of care, when transmitted to SSA, will result in recording the beginning of services in the patient's utilization record. As applicable, the provider enters this information on the following admission and billing forms:

- SSA 1453, Inpatient Hospital Admission and Billing;
- SSA 1478, Extended Care Admission and Billing (being devised);
- SSA 1485, Inpatient Psychiatric and Tuberculosis Hospital Admission and Billing;
- SSA 1483, Outpatient Billing; and
- SSA 1487, Home Health Agency Report and Billing.
- SSA 1486, Inpatient Admission and Billing--Christian Science Sanatorium

There will be occasions when the individual files an application for benefits with an SSA district office after age 65, and retroactive entitlement is found to exist. In these cases, SSA will inform the beneficiary to contact any provider who rendered services to him during the retroactive period. When contacted by the beneficiary, the provider in these situations will initiate a notice of admission under normal procedures before submitting the bill to its intermediary for payment. When the reply to the admission notice is received and it shows the patient is eligible for hospital insurance benefits, the hospital will make refunds that are due the beneficiary as required by its agreement. After making the refund, it will forward the billing to the intermediary. While explanations of wire message formats and codes are included in this chapter, intermediaries should refer to the available telecommunication manuals for the details of telecommunication procedures:

A. Intermediaries directly connected to the Advanced Record System should refer to SSA's "Telecommunications Operating Procedures, Advanced Record System."

B. Intermediaries directly connected to the Blue Cross Association wire system should refer to BCA's "Telecommunications System Principles of Operation, Tributary Station."

#### Identifying the Patient's Health Insurance Record

##### 3502. HEALTH INSURANCE CARD.

As part of the health insurance electronic data processing, HI cards are prepared and mailed by SSA (or in some instances by the Railroad Retirement Board where railroad retirement beneficiaries are involved) to individuals who have established entitlement to health insurance. (See § 3550, Exhibit 1A, Health Insurance Cards.) The HI card is used to identify the individual as being entitled and also serves as a readily available source of essential information to facilitate processing of payment under the program. It contains the beneficiary's name and sex, health insurance claim number, and effective date of entitlement to Hospital Insurance and/or Medical Insurance.

If the intermediary receives an inquiry about replacing a lost or destroyed HI card, it should inform the inquirer to get in touch with the SSA district office nearest his address for assistance in obtaining another one.

3502.1 Temporary Eligibility Notice.--Where there is a need for immediate medical services, the social security district office may



issue a temporary health insurance eligibility notice in advance of a health insurance card. (See Exhibit 1B)

#### 3504. HEALTH INSURANCE CLAIM NUMBERS.

Most HI claim numbers are 9-digit numbers with lettered suffixes, e.g., 000-00-0000-A. However, it might also be a 6 or 9-digit number with lettered prefixes, e.g., A-000000, A-000-00-0000; or, WD-000000, WD-000-00-0000.

The numeric portion of the health insurance claim number frequently includes a social security number. A description of that number follows:

The individual social security number always consists of nine digits, all of which are numeric. This 9-digit number is divided into 3 parts and separated by hyphens as follows: 000-00-0000. The 3 parts are referred to as the "area," the "group," and the "serial," respectively.

The areas range from 001 through 587 and from 700 through 728. All groups except group 00 are possible. The last 4 digits of the social security number, the serial portion are a straight numerical series from 0001 through 9999 within each group.

The claim numbers categorize the social security and railroad retirement claims status of beneficiaries and are essential in locating the patient's central record maintained by the Social Security Administration.

The HI claim number is obtained by the provider from the patient's HI card, or utilization notice, or by provider contact with the SSA district office for assistance. Where the patient cannot furnish a claim number, it may be an indication that he has not filed an application with SSA to establish his entitlement to health insurance benefits, or that SSA action on a pending application has not been completed. In that case, there may be a delay in forwarding the admission notice while the provider awaits the SSA determination on the patient's entitlement.

The potentially valid health insurance claim numbers are as follows:

#### 1. SSA Claim Numbers

000-00-0000-A



000-00-0000-B, B1, B2, B3, B4, B5, B6, B9

000-00-0000-C1, C2, C3, C4, C5 (see note)

000-00-0000-D, D1, D2, D3, D4, D5, D6, D7

000-00-0000-E, E1, E2, E3

000-00-0000-F1, F2, F3, F4, F5, F6, F7, F8

000-00-0000-HB, HB1, HB2, HB3, HB4, HB5, HB6, HB9

000-00-0000-HC1, HC2, HC3, HC4, HC5 (see note)

(NOTE: Subscripts higher than "5" are possible but not likely to occur; there is no limit.)

## 2. RRB Claim Numbers

A-000000, or  
A-000-00-0000

PA-000000, or  
PA-000-00-0000

MA-000000, or  
MA-000-00-0000

PD-000000, or  
PD-000-00-0000

WA-000000, or  
WA-000-00-0000

H-000000

MH-000000

WD-000000, or  
WD-000-00-0000

WH-000000

WCA-000000, or  
WCA-000-00-0000

WCH-000000

PH-000000

WCD-000000, or  
WCD-000-00-0000

JA-000000

In the case of RRB claim numbers, consisting of a prefix and six digits, the numeric portion has no special characteristics.

The highest number assigned is known and is different for each group of prefixes as follows:

<u>Prefixes</u>	<u>Numbers Assigned</u>
A, MA, WA, WCA, PA, JA	000001-991273
WD, WCD, PD	000001-415935
H, MH, WH, WCH, PH	000001-049159

### 3. Special SSA-Health Insurance Only Claim Numbers

000-00-0000-T

000-00-0000-M, MI

(Suffix letter T indicates the individual is entitled to hospital or hospital and medical insurance. Suffix letters M and MI indicate the individual is eligible for medical insurance benefits, but not for hospital insurance benefits.)

### Notice of Admission Procedures

#### 3507. NOTICE OF ADMISSION DATA

The provider will use mail, messenger, telephone, or other means based on prior arrangements to transmit the admission information to the intermediary. (The admission notice part of the admission and billing forms may be sent to the intermediary for this purpose. See § 3550, exhibit 2.) The intermediary will send the admission notice data to SSA central records on a daily basis after review for omissions and inconsistencies. If the review so indicates, the intermediary will take action to obtain the necessary information from the provider before transmission to SSA.

Prior inpatient stay information will not be included in the intermediary wire notifying SSA of the admission. When verification of the prior stay is required, the intermediary will verify this information after receiving SSA's reply and before replying to the provider. SSA's reply to the intermediary will furnish only the number of days on record as of the last date of discharge. The intermediary will make the adjustments to this data and determine the remaining days of eligibility in the spell of illness. The intermediary will enter in items 25 and 27 of the inpatient admission and billing forms (SSA 1453 and SSA 1485, respectively) the verified prior stay dates at the time it makes its payment determination. (See § 3520 on procedures for verifying prior inpatient stays by intermediaries.)

The specific formats for wire (Advanced Record System) transmissions are in § 3550, exhibits 4-11. However, for details of telecommunication procedures, refer to SSA's manual "Telecommunications Operating Procedures, Advanced Record System." The following are explanations of the ARS data entered on Coding Sheet, SSA-1577a, and transmitted to SSA central records by the intermediary or the SSA district office.

3507.1 Prefix. (II).--This code identifies the request as a data message initiated by an intermediary and transmitted to SSA via the ARS telecommunications system. Since the type of message determines the type of editing the message receives, this code also tells the computer which set of edit rules apply to the request. This code serves as a case separator for the computer.

3507.2 Intermediary Number. (IN).--This is a 5-digit number identifying the intermediary servicing the provider who is submitting the admission notice. This number is used in SSA's computer system in lieu of the lengthy name and address. This number identifies the intermediary who will process a Part A claim for this admission. In the event SSA or another intermediary needs information about this admission at a later date, this number tells whom they must contact for the information. If this number is incorrect or not furnished, the Notice of Admission cannot be processed.

3507.3 Provider Number. (PN).--This is a 6-digit number identifying the provider. It must be present on each Notice of Admission or the notice cannot be processed. If a provider number is not received or if the provider number is incorrect or impossible, the notice of admission will be returned for retransmission. This number facilitates the investigation of open items by an intermediary. It is also used to match payment records with open items as SSA processes paid claims. If an incorrect but possible number is received on an admission notice, this may result in delaying the processing of the paid claim when it is received later by SSA.

The first 2 digits of this number represent the State in which the provider is located and the third digit indicates the type of institution (e.g., Hospital, Extended Care Facility, Home Health Agency, Tuberculosis Hospital, or Psychiatric Hospital).

While these numbers will be published in the "Directory of Medical Facilities," the following shows the significance of the last 4 numbers:

PROVIDER NUMBERS  
(Last Four Digits)

- 0001-0999 - Short Stay General Hospitals (short stay specialty hospitals included)
- 1000-1989 - Reserved for future use.
- 1990-1999 - Christian Science Institutions
- 2000-2999 - Long Stay Hospitals not Tuberculosis or Psychiatric
- 3000-3999 - Tuberculosis Hospitals



- 4000-4999 - Psychiatric Hospitals
- 5000-5999 - Extended Care Facilities
- 6000-6989 - Reserved for future use.
- 6990-6999 - Christian Science Institutions. (This represents the extended care type of facility, see also 1990-1999.)
- 7000-7899 - Part A Home Health Agencies
- 7900-7999 - Part B only Home Health Agencies
- 8000-8999 - Independent Laboratories
- 9000-9999 - Reserved for future use.

Hospitals certified for reimbursement for emergency services only, but not certified for full program participation, will be assigned a special provider number with a letter suffix.

Institutions not certified as providers, but meeting the requirements of § 1861 (e)(1) or 1861 (j)(1) of title XVIII, i.e., an inpatient stay in such an institution can prolong a spell of illness, will be assigned a different number. The first two characters will be the State code, the third character will be an "M," and the last three characters will be a serial number beginning with 001. Example: 21 - M - 019.

3507.4 Query Code. (TQ). This is a 1-digit code signal to SSA of the type of action required for handling the claim. It identifies the type of query as follows:

#### PART A QUERY CODES

- |                            |   |
|----------------------------|---|
| 1 Original Query           | Request for benefit eligibility information. When a match of the HI claim number is made, a new open item is established and a wire response will be received from SSA.   |
| 2 Delete Query             | Used to notify SSA to delete an open record on its tape files. No response will be received from SSA.   |
| 3 Continuous History Query | Used to notify SSA to create an open record on its tape files but no response will be received from SSA, (e.g., transfer from a hospital to an extended care facility and both are serviced by the same intermediary. The reply to the original hospital admission query includes the remaining days of eligibility for ECF cases). |

PART A QUERY CODES

## 4 Requery

When an original query (Code 1) has not been answered within 7 days (See 3501 for counting days in this followup.) or other specified number of working days, re-send the query using this code. An open record will be created in SSA's files if none exists, and a response will be received in any event.

## 5 Status Query

This will be used to obtain information from SSA central records when information is needed and when an admission notice is not being initiated. It will be used in connection with inquiries from beneficiaries or providers to the SSA district office or intermediary concerning the possibility of payment for provider services. When this code is used, the data, 3507.1 - 3507.6 will also be transmitted if available. If there is no admission date, the current date will be shown.

No open record will be created, but a reply will be transmitted by SSA.

However, if an actual admission is made on the basis of the information obtained in the reply, an admission query with a query code of "1" must nevertheless be initiated.

3507.5 Claim Number Holder. (CH).--The name of the individual being admitted is entered immediately following the "CH" code. Up to 11 positions of the last name of the individual are entered. If the last name is longer than 11 positions, enter only the first 11 positions. Enter a comma immediately following the last letter of the name or in the 12th position if the name exceeds 11 positions. Immediately following the comma, enter one or two initials. The proper entry for "William B. Jones" would be: "CHJONES,WB." The proper entry for a name with one initial only would be: "CHJONES,W." Do not space within the last name field. Example: "Von Charles" would be entered thus: "CHVONCHARLES,--.". Similarly, do not use hyphens or other punctuation within the last name field. Example: O'Rourke is keyed "OROURKE,--." Do not enter designations such as "JR," "SR," "III," etc.

3507.6 Claim Number. (CN).--This is the health insurance claim number required for processing a notice of admission. The CN codes

indicate that the alphanumeric information which follows is the claim number. This field is variable in length. For example, an entry for a person who has an HI card issued by the Railroad Retirement Board could look like this: "CNA991273." An entry for a person who has an HI card issued by SSA could look like this: "CN123456789F2." The field can contain up to 12 characters and may contain as few as 7 characters.

3507.7 Date of Admission. (DA).--This is entered by the provider on the admission notice showing the month, day, and year in numerals (e.g., 07-01-66 for July 1, 1966). For home health start of care notices show the date of start of care.

For inpatient psychiatric or tuberculosis hospital admissions, the admitted for active care date will be entered in item 10, Form SSA-11485. This is the date the patient was admitted for active treatment or for medically necessary inpatient diagnostic study. This will ordinarily be the day on which the patient is admitted to the hospital or a distinct part of the hospital which is equipped for such treatment or diagnostic services even though the actual treatment or diagnostic procedures did not begin until a later date.

3507.8 Date of Birth. (DB).--This will be shown by the provider as a 6-digit number: 2 digits for month, 2 digits for day, 2 digits for year, e.g., 09-06-00 for September 6, 1900. The date will be transmitted to SSA in that numerical order. For transmission purposes, see § 3550, exhibits 4 - 6. This date should indicate that the patient is at least age 65 in the month the admission notice is sent. While date of birth is useful as identification and should be shown when available, an admission notice will nevertheless be processed where the date of birth field is left blank.

An individual is considered to attain age 65 the day before his birth date. For example, if his 65th birthday is August 1, 1966, he attained July 31, 1966, and is entitled to hospital insurance benefits July 1, 1966.

### 3510. SSA REPLY TO NOTICE OF ADMISSION

Upon receipt of admission notices, SSA checks the HI eligibility and utilization records and prepares a reply to the notice. With the exception of an occasional read or write error in some phases of the SSA computer operations, SSA will transmit a reply to every message received even though there may be a need for an investigation. (See § 3512.7 below, Disposition Codes.) "Disposition" codes are furnished in the reply to enable the intermediary to determine qualifications, original type-of-query identity, and



other conditions which may affect entitlement or a "spell of illness."

The number of hospital or ECF days remaining, home health visits available, the inpatient deductible and blood deductible status furnished in the reply are as of the last date of discharge furnished in the reply. In the reply, SSA will not have determined whether a new spell of illness has begun. The intermediary should examine the "Disposition" codes, the last date of discharge, and the open items to determine remaining eligibility and deductible status.

All SSA replies to admission notices will have either a Type 1, Type 2, Type 3, or Type 4 code as the first character in the reply message. Type 1 identifies the reply to admission notices from hospitals and ECF's. Type 2 concerns replies to start of care notices from home health agencies (see §§3540ff). Type 3 is for all replies to admission notices or start of care reports concerning questionable HI claim numbers or names. Type 4 is for queries rejected by SSA because of errors in the information received in the transmitted query record. See § 3550, exhibits 5 - 11 for specific formats of admission notice replies by wire (Advanced Record System). For details of telecommunication procedures, see SSA's manual, "Telecommunications Operating Procedures, Advanced Record System."

3512. CONTENTS OF THE SSA REPLY TO THE NOTICE OF ADMISSION (TYPE 1).

Type 1 is a reply to a hospital or ECF query indicating remaining eligibility and status of deductible as of the last discharge date recorded in SSA's records.

3512.1 Beneficiary Identification.--The HI claim number sent in the admission notice will always appear in the reply. Where either the name or HI claim number on the admission notice is different than those in the SSA central record, the corrected name or number will appear in a special field in the reply. In this case, the information on the admission and billing form should be changed to reflect the information furnished in the SSA reply. These changes should be brought to the attention of the provider for correction of the billing form before it is submitted for payment.

3512.2 Data Furnished by Provider.--The date of admission will be the same as that on the admission notice.

3512.3 Part A Data.

a. The effective date. This entry will be the first month of entitlement to benefits under Part A. No payment can be made for Part A services furnished before this date.

b. Date of last discharge. If previous inpatient hospital or ECF stays were covered under Part A and the discharge was reported, the latest discharge date reported will appear in the reply. If SSA was notified of an admission, but not of the discharge for that admission, the need to verify the open item will be indicated in the reply to the intermediary. Where this occurs, either the intermediary or Bureau of Health Insurance Direct Reimbursement Operations will verify an open item or prior stay according to §§ 3518 - 3519.

3512.4 Part A Benefits Available As of Date of Last Discharge.

This will show the number of days for which reimbursement may be made, the amount needed to meet the inpatient deductible, and the number of pints of blood needed to meet the whole blood deductible. This information is based on the last date of discharge shown in SSA records; the intermediary determines the actual remaining eligibility with the additional information available to it.

3512.5 Part A Intermediary Number.---This will be the identification number assigned by SSA to the Part A intermediary handling the current admission.

3512.6 Part B Data.---This will show the effective date, the first month of entitlement to benefits under Part B, and, the status of the deductible under Part B as currently shown in the records (as "MET" or "NOT MET;" or coded in the wire: 1 for MET, and 2 for NOT MET).

The "MET" or "NOT MET" codes are informational and should not be acted upon. Even where the indication on a Part A query reply is "MET," the intermediary will initiate a Part B query when acting on a payment under Part B. If the intermediary has been previously notified through the Part B query procedure and keeps records of such notices, the subsequent query may not be necessary. See § 3525 for further explanation.

3512.7 Disposition Code.---This is a code describing the reply. It may encompass caution signals, no record indications, questionable items, errors, etc. In the explanations of the codes, the term "Query Related" is used. The following chart explains a query related or a non-query related condition:

<u>Source of Admission Notice</u>	<u>Open Item Provider on SSA's Record</u>	<u>Query Related</u>
Hospital	Hospital	Yes
Hospital	E C F	Yes
Hospital	H H A	No
E C F	E C F	Yes
E C F	Hospital	Yes
E C F	H H A	No
H H A	H H A	Yes
H H A	Hospital	No
H H A	E C F	No

Listed below are the identification and explanations of the "Disposition" codes:

DISPOSITION CODES - PART A

<u>Disposition Code</u>	<u>Open Item Established</u>	<u>Explanation</u>
00	No	SSA investigation action being taken. (Usually represents a file search to check name and/or Health Insurance Claim Number.) A definitive reply will follow within a few days. If SSA is unable to locate the record or reconcile the name differences, a reply with a disposition code "45" will be sent.
01	Yes	<u>Approval.</u> The beneficiary has never used Part A services. This is an initial admission or start-of-care query for this beneficiary.
02	Yes	<u>Approval.</u> Some prior Part A utilization. Last recorded date of discharge is within 60 days of this date of admission and there are no query related open items on SSA tape records.
21	Yes	<u>Qualified Approval.</u> Query related open item exists on SSA tape records.
22	Yes	<u>Qualified Approval.</u> Admission date precedes date of entitlement to Part A.



<u>Disposition Code</u>	<u>Open Item Established</u>	<u>Explanation</u>
23	Yes	<u>Qualified Approval.</u> Previously reported deceased on a billing form. The admission date is in or prior to month of death.
24	Yes	<u>Qualified Approval.</u> Previously reported deceased by SSA or RRB processing components other than those directly related to the Health Insurance Benefit Utilization operations, and the admission date is in or prior to the month of death.
25	Yes	<u>Qualified Approval.</u> Some prior Part A Utilization. Last recorded date of discharge is beyond 60 days of this date of admission and there are no query related open items on SSA tape records.
41	Yes	<u>Disallowed.</u> Query related benefit is exhausted. It is the intermediary's responsibility to close or delete (as applicable) the open item.
42	(Only for home health services)	<u>Disallowed.</u> No entitlement to Part A, but entitled to Part B. It is the intermediary's responsibility to close or delete a home health open item.
43	No	<u>Rejection.</u> Previously reported deceased on a billing form. The admission date is after the month of death.
44	No	<u>Rejection.</u> Previously reported deceased by SSA or RRB processing components other than those directly related to the Health Insurance Benefit Utilization operations, and the admission date is after the month of death.
45	No	<u>Rejection.</u> Unable to identify beneficiary under HI Claim Number reported in the query. Recheck HI Claim Number and name. If necessary, contact the provider. (A previous reply was sent under code "00".)

<u>Disposition Code</u>	<u>Open Item Established</u>	<u>Explanation</u>
46	No	<u>Rejection.</u> Christian Science ECF involved with other ECF during the current spell of illness.
47	No	<u>Rejection.</u> Duplicate admission.
48	No	<u>Rejection.</u> Not entitled to Part A or Part B benefits.
49	No	<u>Rejection.</u> Unmatched deletion item. (See deletion query codes § 3507.4.)
60	No	<u>Status.</u> NOTE: "Status" indicated in this and the following explanations is related to replies to queries transmitted under Query Code "5".  Investigation action taken to check name and/or Health Insurance Claim Number. A definitive reply will follow within a few days. If SSA is unable to locate the record or reconcile the name differences, a reply with a disposition code "65" will be sent.
61	No	<u>Status.</u> No prior Part A utilization.
62	No	<u>Status.</u> Eligibility has been reduced by prior utilization.
63	No	<u>Status.</u> Previously reported deceased on a billing form.
64	No	<u>Status.</u> Previously reported deceased by SSA or RRB processing components other than those directly related to the Health Insurance Benefit Utilization operations.
65	No	<u>Status.</u> Unable to identify the beneficiary under Health Insurance Claim Number furnished in the query. Recheck the HI Claim Number and name. If necessary, contact SSA district office. (A previous reply was sent under code "60".)

<u>Disposition Code</u>	<u>Open Item Established</u>	<u>Explanation</u>
66	No	<u>Status.</u> No entitlement to Part A, but entitled to Part B.
67	No	<u>Status.</u> No entitlement to Part A or Part B.

### 3513. CONTENTS OF SSA REPLY (TYPE 3)

(For Type 2, see §§ 3540ff.) A Type 3 reply means that SSA could not locate the record of the beneficiary on the basis of the HI claim number furnished in the query, and will review all possible records so that an answer can be given. Another reply (Type 1 or 2) will be sent within a few days either with the corrected data or with a rejection. See § 3550, exhibit 11 for format and contents of reply.

### 3514. CONTENTS OF SSA REPLY (TYPE 4)

This type of reply indicates errors in the admission notice transmitted to SSA. It is a rejection of query by SSA during the initial query message edit operation. The intermediary is to re-query with correct data.

An asterisk(\*) in the replies is used as a field separator, but only when the preceding field contained an error condition in the query message. See § 3550, exhibit 11 for format and contents of reply.

### 3518. INTERMEDIARY ACTION ON SSA REPLIES.

Generally, the SSA reply to an admission notice will be complete enough to permit the intermediary to compute the patient's eligibility where the reply does not indicate an open item or there is no prior-inpatient stay involvement. If the intermediary determines that the reply contains the information the provider needs to assess eligibility for billing purposes, it will forward the reply to the provider.

3518.1 The Report of Eligibility.--The "Report of Eligibility" part of the inpatient admission and billing forms (see § 3550, exhibit 2, SSA 1453 and SSA 1485) may be used by the intermediary as a reply to the admission notice received from the provider. Whether the reply will be given by telephone, mail, or wire to the provider, it will contain eligibility information similar to the content in the "Report of Eligibility" part of the admission notice. If there is no eligibility or less than 10 days eligibility remains, the intermediary will telephone or wire the reply to the provider. (For guarantee of payment purposes, a



hard-copy reply will also be furnished to the provider as a written confirmation to a telephone reply. The date of the telephone reply constitutes the date of notification. See § 3404.)

Outlined below is an explanation of the eligibility information in the "Report of Eligibility."

Item A. Effective Date--Hospital Insurance. The month, day, and year of the patient's entitlement to hospital insurance benefits (Part A) will be shown. If not entitled, an entry will be made to show this.

Item B. Effective Date--Medical Insurance. The month, day, and year of the patient's entitlement to medical insurance benefits (Part B) will be entered. If applicable, an entry will be made to indicate that the patient is not entitled to Part B benefits.

Item C. Hospital Days Remaining. Enter in the "Full" block, the number of inpatient days for which payment can be made in full. Enter in the "Coinsurance" block, the number of inpatient days for which the patient is responsible for coinsurance payments.

Item D. Medical Plan Deductible. The status of this deductible will be indicated by entering an "X" in the block designated "MET" or "NOT MET." (This indication is informational, see § 3512.6.)

Item E. Remaining Inpatient Deductible. Enter the dollar amount, if any, of the \$40 inpatient deductible yet to be met for the current spell of illness.

Item F. Pints Remaining--Blood Deductible. Enter the number of pints of blood, if any, needed to satisfy the whole blood deductible for the current spell of illness.

Item G. ECF Days Remaining. Enter the number of inpatient extended care facility days available, if any, for the current spell of illness.

Item H. HHA Visits Remaining--Hospital Insurance and Medical Insurance. Show the number of home health visits remaining under hospital insurance. If the intermediary also needs to furnish the number of HHA visits remaining under Part B, it may obtain this information by using query code 5 and entering 007000 in the provider field of the query.

Item I. Psychiatric Days Remaining. This information will be shown where the admitting hospital is a psychiatric hospital.

Item J. Open Item Information. The intermediary will use Item J of the "Report of Eligibility" for open item development entries. If the intermediary (or Bureau of Health Insurance Direct Reimbursement if the provider deals directly with the Government) determines that the reply indicates an open item or prior-inpatient stay, it will initiate the action outlined in §§ 3519 and 3520 below, and update the reply on the basis of the results of the development.

Remarks. Enter here any necessary explanation of eligibility information. This will include corrections in the name or health insurance claim number reported by the provider. When changes of this sort are reported, the provider should be informed to change the name or HI claim number information on the billing form.

This section may also be used as necessary to request the provider to verify reports of death shown in the patient's SSA central record.

#### 3519. OPEN-ITEM DEVELOPMENT

Where the SSA reply to the admission notice transmitted by the intermediary shows an open item, the intermediary checks the provider code number shown in the open item, refers, if necessary, to the Directory of Medical Facilities, and takes the following action.

3519.1 If the Intermediary Services the Open-Item Provider.--It will screen records internally to ascertain the disposition of the item or contact the open-item provider to verify the stay, to obtain information on inpatient and whole blood deductibles, and to request an immediate submittal of a billing, if appropriate. It will be necessary to delay processing the bill for the current admission until any prior billing is settled. The intermediary should set up a control on the open-item to assure submittal of the bill from that provider. This is necessary to avoid paying bills out of sequence for the same beneficiary.

However, if the verification and the SSA reply indicate that the inpatient and any whole blood deductibles are satisfied and the spell of illness and coinsurance days will not be affected, the intermediary may furnish a provisional reply to the current admission notice without waiting for the prior billing. When the prior billing is received, the intermediary may then inform the current stay provider of any changes to the earlier reply.



3519.2 If the Intermediary Does Not Service the Open-Item Provider. The intermediary that transmitted the admission notice will request the servicing intermediary to contact that provider to resolve the issue. It may be necessary to refer to the Directory of Medical Facilities to obtain the proper servicing intermediary address. (If either the current-stay or prior-stay provider deals directly with the Government, the Bureau of Health Insurance Direct Reimbursement will contact the servicing intermediary or be contacted by it, as applicable.)

The intermediary making the request will indicate to the intermediary servicing the open-item provider the need to obtain a billing, if appropriate, from the provider immediately. It will also request the servicing intermediary to furnish it information on all deductibles and dates affecting spell of illness and coinsurance days as soon as possible. If the prior-stay intermediary has not yet received the open-item provider's billing at the time it replies, it will notify the current-stay intermediary as soon as the bill is received, so that the current-stay billing may be processed without delay. The current-stay intermediary will followup with the intermediary servicing the open-item provider after 7 calendar days have elapsed if no response is received.

#### 3520. VERIFICATION OF PRIOR INPATIENT STAY

A recent prior admission or discharge may indicate whether the patient has limited or no eligibility in the current spell of illness, whether the \$40 inpatient or whole blood deductibles are applicable to this hospital stay, or whether the coinsurance provision will be in effect. Inpatient benefits are related to a spell of illness and, once begun, a spell of illness cannot end until an individual has not been an inpatient of a hospital or extended care facility (ECF) for 60 consecutive days. An inpatient stay in a hospital or extended care facility continues a spell of illness and prevents the start of a new spell of illness with the current admission. There is also a need to verify prior stays for ECF admissions where no open hospital item is on record and the date of last discharge recorded is earlier than the alleged related discharge date.

An additional inpatient stay verification is necessary in the case of psychiatric and tuberculosis hospitals, related to stays in such institutions during the 90 days prior to the first day of entitlement. Development of this information will begin with completion by the provider of sections 11 and 12 of form SSA-1485. It will flow through the same steps as in the following §§ 3520.1 and 3520.2.



3520.1 Prior-Stay Institution is a Participating or Covered Emergency Services Provider.--The SSA reply will show the "Date of Last Discharge" from a covered stay. If this entry is consistent with the prior-stay allegation on the current-stay provider's admission notice, no further action is required. If it is not, the intermediary should consult its records or contact the prior-stay provider or servicing intermediary in the same manner as for open items in Section B above to verify the entry and obtain a claim, if appropriate. As discussed in § 3519.1, it may be necessary to wait until an admission-billing form is obtained from the prior-stay provider before processing the current billing.

3520.2 Prior-Stay Institution Is Not A Participating or Covered Emergency Services Provider.--The SSA record will not contain a discharge date for a non-covered prior-stay in a nonparticipating institution which may be shown on the admission notice. If the SSA reply shows a last discharge date that is more than 60 days before the day of the current admission, a contact will be necessary with the nonparticipating institution to verify the allegation on the admission notice and determine whether the stay prolonged the spell of illness.

There is no need to contact a prior-stay nonparticipating provider where there is a last discharge date in the SSA reply and there are less than 60 days between this last discharge date and the current date of admission. In these cases the current-stay continues the spell of illness in any event. If no last discharge date is shown on the SSA reply, it will also not be necessary for the intermediary to verify a prior-stay in a nonparticipating institution (including a nonparticipating institution which meets the requirements for coverage of emergency services).

Where the intermediary determines by reference to the Directory of Medical Facilities that the prior-stay institution is one which does not meet the definition of a hospital or ECF for purposes of prolonging a spell of illness, no further intermediary action is required.

### Part B Queries and Replies

#### 3525. OUTPATIENT AND PART B HOME HEALTH QUERY

When the intermediary receives an outpatient hospital or Part B home health billing, it will query the SSA central records for the Part B deductible status information, even though it may have been

indicated in the reply to a prior Part A query that the Part B deductible had been met. SSA's records identify Part B physicians' services carriers who have been notified that the deductible is met in reply to a Part B query, and only such intermediaries are notified in the event the beneficiary's Part B entitlement is terminated during the year. Part A queries and Part B queries by Part A intermediaries are not earmarked in this manner. Thus, only if a Part A intermediary is also a Part B physicians' services carrier, maintains beneficiary status records in that capacity, and has been notified through the Part B query procedure that the deductible has been met, may a subsequent Part B query be unnecessary.

See § 3527 ff. for the Part B query and the reply. The query code that will be used for this query is I. J is the code when following up on this query. A followup will be made after 7 days have elapsed. Exclude Saturdays, Sundays, and legal Federal holidays (see § 3404) in counting days for the 7-day followup.

#### 3527. PART B QUERIES--GENERAL.

A. Carry-over Expenses.--Expenses incurred in the last three months of a calendar year which apply toward the Part B deductible for that year, also apply toward the Part B deductible for the following year. SSA maintains a record of this. Therefore, when querying SSA, the intermediary reports the "First Incurred Dates" and "Reasonable Charges" during the first nine months, and those during the last three months, in separate fields.

B. Limitation on Noninpatient Psychiatric Expenses.--The limitation on incurred expenses for psychiatric treatment of individuals who are not inpatients of hospitals applies to physicians' services only. It does not apply to provider services. PART A INTERMEDIARIES SHOULD DISREGARD THIS ITEM ON QUERIES. IT IS EXPECTED THAT IT WILL NOT BE IN REPLIES TO THEM UNDER SYSTEMS BEING CONSIDERED.

C. Two Calendar Years Involved.--When the request for payment includes incurred dates that are not in the same calendar year, prepare separate queries.

D. Outpatient Charges.--The intermediary query to SSA, after receipt of an outpatient hospital billing form (SSA-1483) should show all reasonable medical plan charges from item 17 of the form and no more than \$20 of the reasonable hospital plan charges from item 17.



E. Selecting Query Codes. Various query codes are available to identify the type of data that the intermediary is transmitting to SSA.

To correct a money amount previously reported in a routine query coded I, the intermediary repeats the incorrect amount in a new query using a C query code. The C code alerts SSA that a corrected amount will follow. The intermediary then transmits the corrected amount in a query coded E. The C and E queries must be transmitted the same day or SSA will reject the query. If a followup is made, both D and F queries must also be sent the same day.

If the intermediary wants to cancel the entire previous query (I code) instead of correcting it, he so indicates in a new query using an A query code.

### 3529. FORMAT FOR PREPARING THE PART B QUERY TO SSA (ADVANCED RECORD SYSTEM)

For details of telecommunications procedures, intermediaries directly connected to the Advanced Record System should refer to Volume I of the SSA Telecommunications Operating Procedures (T.O.P.) Advanced Record System, and the related addenda. Intermediaries directly connected to the Blue Cross Association's wire system should refer to Telecommunications System Principles of Operation, Tributary Station, issued by the BCA.

Transmit data to SSA as indicated below. Also see Exhibit 12, ARS Query Coding Sheet. The data following each field identification code must be left-justified and each field must be terminated by a period. The omission of a period will cause an edit error in two fields of the message and may cause an edit error in two messages. When the teletype operator discovers that she has made an error in a message, she must exactly follow the error correction procedures specified in the "T.O.P." mentioned above.

The HI claim number (CN field) and the beneficiary's name (CH field) must appear in every query. An error in the HI claim number will delay processing the query.

### Field Identification Code

- II      Prefix Code. This indicates the type of traffic and the start of a new query. If the prefix code is shown incorrectly, it will result in two queries being combined. An "II" must be shown to identify each query.



The field identification codes below are followed by (F) when the field is fixed and by (V) when the field is variable.

<u>Field Identification Code</u>		<u>No. of Characters</u>	
IN	(F)	5	<u>Intermediary Number.</u> This is a 5-digit number that SSA has assigned to the intermediary.
IC	(V)	10	<u>Intermediary Control Number.</u> The intermediary may assign himself a control number, and show it here, for SSA to use in the reply. This field is variable in length up to a maximum of 10 positions. A control number of 365 is entered "IC365."
TQ	(F)	1	<u>Type of Query.</u> The following query codes are used to indicate the type of data that the intermediary is transmitting to SSA.

Query Code:

- A Void Query. When a prior query is to be completely cancelled and not replaced, **cancel** it by retransmitting the same prior query data using an A query code.
- C Credit Query. Use this code when sending a query to credit an amount given in a prior query. This removes the amount given in a previous I-coded query, and indicates that an E-coded query will follow with the corrected amount. (SSA must receive the C and E queries on the same day or it will send a reject reply using disposition code 47.)
- E New Debit Query. Use this code to report a new debit after an amount previously reported in an I-coded query has been credited in a C query. SSA updates its deductible totals on the basis of this type of query.
- G Routine Claim Query--Termination Involved. Use this code to report amounts for services obtained during a period in which the individual was still entitled to Part B, after SSA has furnished the information that the beneficiary's entitlement to Part B payments has terminated for a reason other than death (disposition code 44). SSA updates its records on the basis of this type of query.

Query Code:

- I Part B Deductible and Query. Use this query code to request status when a claim is pending. SSA updates its deductible totals on the basis of this type of query.
- K Part B Entitlement Status Query. Use the K query code to request status when no claim is pending. It is used when the intermediary needs information from SSA's records to process correspondence, to assist in resolving questionable items prior to submitting a routine claim inquiry, etc. A code K query must have a year indication in the (SI) field. The month may be an actual month or two zeros. The money fields may be omitted or zero filled. SSA does not update on the basis of this type of query.

NOTE: Second requests may be made if no reply has been received after 7 days. Queries should not be followed-up routinely, since indiscriminate use of the follow-up codes will further delay replies. To indicate that this is a second request to a previously submitted query, use these query codes:

Use Query Code:            To Follow up on Prior Query Codes:

B	A
D	C
F	E
H	G
J	I
K	K

<u>Field Identification Code</u>	<u>No. of Characters</u>
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CH	(V)	14	<u>Claim Holder.</u> In this field furnish the name and sex of the "claim holder," i.e., the beneficiary or potential beneficiary. Show up to 11 letters of the surname followed by a comma and 1 or 2 initials. If the surname is less than 11 letters, key a comma immediately after the last character of the surname. One or two initials are entered immediately following the comma. Do not show Jr., Sr., III, etc. Show two-word surnames as one word. Do not use hyphens, apostrophes,
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<u>Field Identification Code</u>		<u>No. of Characters</u>
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or other punctuation with the surname field. Immediately after the initial or initials, show a period. Right after the period key a one-position sex code: "1" for male, "2" for female, and "3" for unknown.

CN	(V)	12	<u>Claim Number.</u> The HI claim number follows this code. (See § 3504 for an explanation of HI claim numbers.)
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NOTE: When the SI code precedes a field, it must be followed by an RC and/or PC field except where the query code (TQ) is a K. When all the expenses being reported in this query were incurred in the last quarter of the year, omit the SI, RC, and PC fields.

SI	(F)	4	<u>First Date Incurred (January through September).</u> Use this field when the first expense being reported in this query was incurred during the first 9 months of the year. When the request for payment includes more than one date, report the earliest date. Show month and year in that order. January is shown as "01," 1968 as "68," etc.
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NOTE: It is imperative that the cents positions be included in all money fields of the query. But do not place a decimal point between the dollars and cents.

RC	(V)	6	<u>Part B Reasonable Charges for Medical Care Other Than Psychiatric (January through September).</u> Part A intermediaries show all reasonable charges for medical care that are being reported in this query. These expenses must have been incurred during the first nine months of the year. This field has a maximum of six characters. Examples: For \$150.00, transmit: RC15000. For \$22.90, transmit: RC2290. If charges exceed \$9,999.99, transmit that amount.
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Field Identification Code	No. of Characters	
PC (V)	5	<u>Reasonable Charges for Noninpatient Psychiatric Care (January through September).</u> PART A INTERMEDIARIES DISREGARD THIS ITEM.

NOTE: When the CD code precedes a field it must be followed by a CC and/or CP field. When all the expenses being reported in this query were incurred prior to the last quarter, omit the CD, CC, and CP fields.

CD (F)	4	<u>First Date Incurred (October through December).</u> Transmit the earliest date being reported in this query that falls in this part of the year. This field is 4 positions in length. Show two digits for the month and the last two digits of the year in that order.
CC (V)	6	<u>Part B Reasonable Charges for Medical Care Other Than Psychiatric (October through December).</u> Part A intermediaries transmit the total reasonable charges for medical care that are being reported in this query. The field is a maximum of six positions. Examples: For \$1,010.00, show: CC101000. For \$20.00, transmit: CC2000. If charges exceed \$9,999.99, transmit that amount.
CP (V)	5	<u>Part B Reasonable Charges for Noninpatient Psychiatric Care (October through December).</u> (PART A INTERMEDIARIES DISREGARD THIS ITEM.)

### 3531. SSA RECORD MAINTENANCE AND REPLIES

SSA maintains an up-to-date record of each beneficiary's status, using expenses reported in queries received from the intermediary to update the deductible amount on the SSA tape record. The record will include separate totals for psychiatric and non-psychiatric expenses. SSA will also maintain the amount of any carry-over deductible. Upon receipt of each new inquiry, SSA notifies the current inquirer of the amount of the deductible that still has not been satisfied.

SSA's reply gives the status prior to receipt of the current inquiry and enables the intermediary to determine whether he can make a payment. EXCEPTIONS: Replies containing disposition codes "21" and "22" furnish status after adjustments have been made based on the current inquiry. (See query codes A, C, and E. § 3529.)

SSA will not furnish a deductible status in reply to an intermediary when:

a. The reported incurred date precedes the month of the beneficiary's entitlement to Part B, or

b. His entitlement to Part B has ended.

There is an exception to item b. above, SSA will reply when the intermediary used a query code of "G" indicating that he is aware of the termination but is reporting expenses incurred prior to termination.

3533. ADVANCED RECORD SYSTEM (ARS) PART B REPLY RECORD FORMAT (See exhibits 13 through 16.) SSA uses a period (.) to terminate each field except:

1. an asterisk (\*) is shown instead of a period at the end of a field containing data that was incorrect in the query, and

2. no period is shown after the last field in each line, although an asterisk is placed there when appropriate.

A field is not split between two lines. SSA separates replies by five blank lines. The data is transmitted in the order indicated below.

Type of Reply Indications. The type of reply code is always shown as the first position in the first line of a reply. There are three types of Part B replies to Part A intermediaries:

Type 3 - Acknowledgement only. SSA is unable to locate the beneficiary's record on the basis of the HI claim number or beneficiary name furnished in the query. SSA is investigating and will send a type 4 or 6 reply within a few days.

Type 4 - Rejected in edit. SSA uses a code of 4 to reject a query because of incorrect data. The intermediary should requery with the correct data.

Type 6 - Routine reply. The 6 indicates the beginning of a routine reply about Part B benefits. Check the disposition code for qualified replies.

No. of  
Positions

- 5 Intermediary Number. This is a 5-digit number assigned by SSA to the intermediary.
- 12 HI Claim Number. This is the beneficiary's claim number, which may vary from 7 to 12 positions. The field is 12 positions; any unused positions following the seventh position will be blank.
- 2 Disposition Code. This is a 2-digit number that describes the reply.

Disposition Code  
(Columns 19-20)

Condition

- 00 There will be a delay; SSA is investigating. Definitive reply will follow.
- 01 Approval. This is an unqualified reply containing data requested in the query.
- 02 Approval. Beneficiary's entitlement to Part B terminated by death.
- 21 Acknowledgement. Query Code A (void credit) has been received and posted. This reply furnishes status after adjustment has been made based on the current query.
- 22 Acknowledgment. Query Codes C and E (adjustment credit) has been received and posted. This reply furnishes status after adjustment has been made based on the current query.
- 41 Rejected. Date of first expense is prior to entitlement date.
- 42 Rejected. Individual has never been entitled to Part B.
- 43 (not used)



Disposition Code  
(Columns 19-20)Condition

- 44 Rejected. Beneficiary's entitlement to Part B terminated for reasons other than death.
- 45 Rejected. Unable to identify beneficiary by the HI claim number given in the query. Recheck name and HI claim number.
- 47 Rejected. Query code C and E received without the counterpart. Resubmit entire adjustment, using C and E again, not the follow-up query codes.
- 81 Edit error. HI claim number. Resubmit query.
- 82 Edit error. Query code. Resubmit query.
- 83 Edit error. Name. Resubmit query.
- 84 Edit error. First incurred date. Resubmit query.
- 85 Edit error. Reasonable medical charges. Resubmit query.
- 86 Edit error. Reasonable psychiatric charges. Resubmit query. (PART A INTERMEDIARIES DISREGARD ITEM 86.)
- 87 Edit error. Carry-over data. Resubmit query.

Additional codes may be assigned as dictated by need and negotiation agreements.

No. of  
Positions

- 4 Part B Entitlement Date. This is the month and year that the beneficiary became entitled to Part B supplementary medical insurance payments. SSA transmits two digits for the month and the last two digits of the year. When the month is one digit, it will be preceded with an "0." Example: for September 1969, SSA shows 0969.
- 6 Beneficiary's Date of Birth. This information is taken from SSA records and is transmitted with two positions each for the month, day, and year. Example: for January 27, 1900, SSA transmits 012700.

No. of  
Positions

- 4 Part B Remaining Deductible. This is the amount of the deductible that has not been met prior to receipt of the present query.

NOTE: Data that is transmitted only in certain replies, as needed, is preceded by a trailer record code to indicate its presence and what it is. In any Part B reply, none, one, or more trailer record codes may be present. The trailer record codes and the fields that they precede are shown below.

No. of  
Positions

- 10 Intermediary Control Number. A record code of A precedes this field. This is a repeat of the control number that the intermediary included in the query.
- 14 Corrected Surname. A record code of B precedes this field. A corrected surname is shown only if the name of the beneficiary submitted in the query is incorrect.
- 12 Corrected HI Claim Number. A trailer code of C precedes this field. The corrected number is included only if the HI claim number submitted in the query is incorrect.
- 5 Reasonable Charges Remaining for Psychiatric Care. A trailer record code of D precedes this field. PART A INTERMEDIARIES DISREGARD THIS ITEM. IT IS EXPECTED THAT IT WILL NOT BE IN SUCH REPLIES UNDER SYSTEMS BEING CONSIDERED.
- 4 Part B Termination Month and Year. A record of F precedes this field. SSA transmits 2 digits for the last month covered and the last 2 digits of the year. Expenses incurred through the last day of this month are reimbursable.
- 1 or 2 lines Representative Payee. A record code of G precedes this field. When SSA has knowledge that someone is authorized to act on behalf of the beneficiary, the name and address is transmitted here. HOWEVER, PART A INTERMEDIARIES SHOULD DISREGARD THIS INFORMATION ON REPLIES CONCERNING PART B PROVIDER SERVICES. IT IS EXPECTED THAT THIS ITEM WILL NOT BE IN SUCH REPLIES UNDER SYSTEMS BEING CONSIDERED.

Notice of Start of Care Procedures

3540. COMPLETION OF START OF CARE NOTICE BY HOME HEALTH AGENCIES  
The home health agency will have completed items 1 - 16 on the start of care notice (admission) part of the SSA-1487, Home Health Agency Report and Billing Form at the time the patient first receives home health services. The intermediary will review for omissions and inconsistencies, the information on the start of care notice. If the review so indicates, the intermediary will take action to obtain the necessary information from the provider before transmission to SSA central records.

Most of the start of care items on form SSA-1487 are equivalent to those on Form SSA-1453 (Inpatient Hospital Admission and Billing) and should be reviewed in the same way. The following items are peculiar to home health services.

Item 10. Date Care Started. This item will indicate the date on which home health services actually began.

Items 11 and 12. Name and Address of Institution, If Any, Caring For Condition Later Requiring Home Health Services and Verified Dates of Stay. The home health agency will complete item 11, if applicable, showing the name and address of the hospital or extended care facility from which the patient was discharged.

The verified dates of prior stay will be shown in item 12 only when they are taken from official hospital records or extended care facility records furnished to the home health agency. These dates may be available where the home health agency has an arrangement with the provider, and in situations where a hospital has a home health department.

The intermediary will need to obtain verified dates of prior stay where this information is not entered in the start of care notice. If this information is in the intermediary's files, i.e., it services the institution in item 11, these dates will be considered verified. If the dates are not in the intermediary's files, it will need to contact the institution, or the appropriate intermediary (or Bureau of Health Insurance Direct Reimbursement) servicing the institution in question, to verify the dates. Upon verification, the intermediary or the home health agency will enter these dates in item 12 of the billing copies of form SSA-1487. (See § 3547.)



Where a patient receiving home health services under a plan from another home health agency transfers to a new home health agency, the current home health services are a continuation of the original plan and the first current visit is within a year after the qualifying discharge from an institution, the name of the prior home health agency will be shown in item 11. The inclusive dates, if verified, during which the patient received the prior home health services will be shown in item 12. The entries in items 11 and 12 for prior home health services will also be made where the present service was interrupted by confinement in a hospital or extended care facility.

Item 13. Date Home Health Agency Plan Established. The date the home health plan is established by the physician will be shown in this item.

The date the plan is established must be within 14 days after the discharge from a 3-day inpatient hospital stay, or a covered extended care facility stay in order for the services to be covered under hospital insurance.

#### 3542. TRANSMISSION OF START OF CARE NOTICES

When the home health agency has secured the health insurance claim number and has completed the start of care items on form SSA-1487, it will either furnish the admission copy(ies) of form SSA-1487 (See § 3550, exhibit 3) to the intermediary, or telephone the information to the intermediary, according to the arrangements made.

See § 3507.1 - 3507.8 for the query format and codes which are also to be used for home health agency services.

#### 3544. SSA REPLIES TO START OF CARE NOTICES

See § 3550, exhibits 5 and 10 for an explanation and sample of the format of the reply to the start of care query. The reply will contain the following information:

A. Type. The reply to the Start of Care notice will always be a Type 2 Code. (See 3550, Exhibit 10.)

B. Part A Intermediary Number for Home Health Agency. This will be the identification number assigned by SSA to the intermediary to whom the reply to the Start of Care notice should be sent.

C. Health Insurance Claim Number. This will be the same HI claim number as reported on the query. See § 3512.1 for treatment of beneficiary claim number discrepancies.

D. Disposition Code. This code describes the reply. (See § 3512.7 for disposition codes.)

E. Date of Start of Care. This shows the date services began as indicated on the start of care notice.

F. Part A Visits Available. This gives the remaining number of visits which may be reimbursed under Part A, provided the other requirements are met. When furnishing the remaining number of visits, SSA will not consider whether all the requirements for hospital insurance benefits are met, such as the prior 3-day inpatient hospital stay requirement, whether a new spell of illness has begun, etc. The intermediary will determine the actual number of visits available taking into consideration the number of visits available as shown in the SSA reply; the last discharge date; whether the patient's condition is related to the one for which he was treated in the hospital or extended care facility; the effect of a new spell of illness based on a date of discharge later than that available from SSA central records; whether the date of start of care is within the one-year period; and, the date the current plan of treatment was established.

G. Part B Visits Available. This information shows the potential remaining home health visits which may be reimbursed under Part B.

H. Part B Deductible Status. This item will show if the \$50 deductible is "MET" or "NOT MET". The "MET" or "NOT MET" notation will be informational only. However, no further action is to be taken by the intermediary to ascertain deductible status at this time, even if it determines that there are no Part A visits available and that the visits will be chargeable to Part B. The intermediary takes this action when it receives the home health agency Part B billing. At that time, the intermediary will use the Part B query system to query SSA central records for additional Part B deductible information. (See § 3525 for a further explanation of the need for a Part B query by the Part A intermediary. See §§ 3527ff. for explanation and format of the Part B query system.) Reasonable charges must first be determined by the intermediary before dollar amounts may be listed on the Part B query. See § 3550 exhibit 12 for the query format to be used by the intermediary.

I. Psychiatric Expenses Incurred. The Part B noninpatient expenses limitation will be shown as "MET" or "NOT MET." This item is informational only. The limitation applies only to physicians' services, and not to the home health agency's services.

J. Last Discharge Date. This shows the last date recorded in SSA central records of a discharge from a hospital or extended care facility.

Where SSA central records were notified of an admission or a start of care but not of the discharge, an open item will be indicated in the reply to the intermediary. This will show the Intermediary Number of the intermediary servicing the open item provider, the Provider Number of the open item provider, and the Admission Date, the date the individual was admitted into the institution. (See § 3519 for verifying open items.)

K. Part A Effective Date. This indicates the date the patient became entitled to hospital insurance and is useful in determining the earliest date home health services may be payable under Part A. Where there is entitlement to both Part A and Part B benefits, Part A benefits must be used, if applicable, before payment for home health services can be made under Part B.

L. Part B Effective Date. This indicates the date the patient is enrolled under medical insurance. Thus, benefits may be available under this program if benefits are not payable under Part A.

#### 3545. INTERMEDIARY'S REPLY TO THE HOME HEALTH AGENCY (THE REPORT OF ELIGIBILITY)

The SSA reply will generally be complete enough to compute the patient's eligibility if the reply does not indicate an open item. The intermediary may use the Report of Eligibility part of the home health agency report and billing form as a reply to the start of care notice. The information on the Report of Eligibility may be furnished to the home health agency by mail, messenger service, or telephone, in accordance with prior arrangements. Outlined below is an explanation of the eligibility information in the Report of Eligibility.

Item A. Effective Date, Hospital Insurance. The month, day, and year of the patient's entitlement to Part A will be shown.

Item B. Effective Date, Medical Insurance. The month, day, and year of the patient's entitlement to Part B will be shown.



- Item C. Date of Start of Care. This is the date shown on the start of care notice.
- Item D. Hospital Insurance Visits Available. Show the number of Part A visits available based on the SSA reply, the information in the start of care notice, prior-stay verification, and any open-item investigation.
- Item E. Medical Insurance Visits Available. Show the potential remaining Part B visits available.
- Item F. Last Discharge Date. Show the date of last discharge from a hospital, or extended care facility, based on the SSA reply and any prior-stay verification or open-item development.
- Item G. Medical Plan Deductible. Show for informational purposes whether the Part B deductible is met or not met.
- Item H. Outpatient Psychiatric Expense. Show for informational purposes whether the Part B psychiatric expense limitation is met or not met.
- Item I. Remarks. Show any necessary explanation of eligibility information. Corrections in names or HI claim numbers reported by SSA central records will also be shown here. Where changes of this sort are reported, the provider should be informed to change, as appropriate, the name or HI claim number information on the billing form.

This section may also be used as necessary to request the provider to verify information, e.g., reports of death shown in the patient's SSA central records.

- Item J. Where there is an open item, the intermediary will initiate the action outlined in § 3547. Upon resolution of the open item, the intermediary will forward the reply to the current-stay provider. If the intermediary uses the Report of Eligibility as the reply to the start of care notice, it should use item J of the form for the open-item development entries and items A - I for eligibility information.

3547. VERIFYING STAY IN INSTITUTION CARING FOR CONDITION LATER  
REQUIRING HOME HEALTH SERVICES

If the patient received prior services for a related condition in a hospital or extended care facility, or prior home health services, the start of care notice should show the name and address of the

institution or agency. If item 12, Verified Dates of Stay, is not completed, the intermediary will verify the prior 3-day inpatient hospital stay. (No verification will be made with other intermediaries or BHI Direct Reimbursement until after the SSA central records reply to the start of care notice is received.) In any event, it will also ascertain whether the extended care facility stay was covered.

In counting days for a qualifying 3-day hospital stay, the day of admission is counted as a day, but the day of discharge is not counted as a day. In cases involving prior inpatient hospital services, the date of discharge may not be prior to 7/1/66. Where discharge from an extended care facility is involved, the date of discharge may not be earlier than 1/1/67 since extended care services are not covered until that date.

Since the SSA reply to the start of care notice will not show the status of the prior provider, the intermediary will have to refer to the Directory of Medical Facilities and check whether the provider is a participating hospital, extended care facility, or home health agency, or a hospital approved for emergency services. It is possible that the Directory of Medical Facilities may not show the status of the provider because the signing of the agreement may have been too recent for issuance in the directory. If the provider is not listed, the intermediary should attempt to obtain the status from the Bureau of Health Insurance Regional Representative.

Where the prior stay involves a hospital, verify the dates of inpatient stay.

Where a participating extended care facility is involved, verify the coverage of the extended care services and the date of discharge. Where a participating home health agency is involved, verify the number of visits used by the patient under both hospital insurance and supplementary medical insurance, the period during which home health services were provided, and the dates of hospital or extended care facility stay if the home health services were interrupted by such stay.

3547.1 The Intermediary Services the Prior Provider.--If the intermediary services the prior provider and the home health agency has not verified the dates of stay, the intermediary should screen its own records for this information. Where the intermediary's records do not contain sufficient information, it should contact the prior provider to obtain it.



3547.2 Another Intermediary Services the Prior Provider.--If another intermediary or Bureau of Health Insurance Direct Reimbursement had serviced the prior provider and the home health agency has not verified the dates of stay, contact the other intermediary or BHI Direct Reimbursement for the pertinent information.

3548. OBTAINING OPEN-ITEM INFORMATION

If the SSA central records reply to the start of care notice shows an "open item," this would be an indication that the patient may have received services (inpatient hospital, extended care, or home health services) and that payment action on these services has not been completed.

3548.1 The Intermediary Services the Open-Item Provider.--The intermediary should screen its own records for dates of stay information. If the intermediary's records do not contain sufficient information, it should contact the open-item provider to obtain it and request an immediate submittal of a claim, if appropriate.

After the pertinent information is obtained, update the SSA reply and transmit the Report of Eligibility information to the current home health agency. If the information cannot be obtained, set up a control on the open-item provider to assure submittal of the bill from that provider. This is necessary to avoid paying bills out of sequence for the same beneficiary. However, if the pertinent information is obtained, the intermediary may furnish a provisional reply to the home health agency without waiting for the prior services billing. When the prior services billing is received, the intermediary may then inform the provider of any changes to the earlier reply.

3548.2 Another Intermediary Services the Open-Item Provider.--Where another intermediary or BHI Direct Reimbursement is involved and the current home health agency has not verified the dates of stay, contact the other intermediary (or BHI Direct Reimbursement) for the pertinent information.

The intermediary servicing the open-item provider should be advised of the need to obtain a billing from that provider as soon as possible. On the basis of the information obtained from that intermediary, the current intermediary can make a provisional reply to the home health agency. If the other intermediary is unable to provide the necessary information, follow up on the request in 7 calendar days. Update the reply, as appropriate, and furnish it to the home health agency when informed that the prior bill has been processed.



## 3550. EXHIBITS

Exhibit No. 1A. Health Insurance Cards

Exhibit No. 1B. Temporary Notice of Eligibility

Exhibits Nos. 2A and 2B. Admission Notices--Reports of Eligibility

Exhibit No. 3. Start of Care Notice--Report of Eligibility

Exhibit No. 4. Part A--Notice of Admission Coding Sheet

Exhibit No. 5. Explanation of Part A Reply--Exhibits 6-10.




Exhibits Nos. 6 through 11. Type 1 through 4 Replies to  
Admission and Start of Care Notices.

Exhibit No. 12. Part B-Inquiry Coding Sheet

Exhibits Nos. 13 through 16. Type 6, Type 3, and Type 4 Replies  
(Part B) Advanced Record System



## HEALTH INSURANCE CARDS

Health  Insurance	
<b>SOCIAL SECURITY ACT</b>	
NAME OF BENEFICIARY <b>JANE Q. DOE</b>	
CLAIM NUMBER <b>000-00-0000 B</b>	SEX <b>FEMALE</b>
IS ENTITLED TO EFFECTIVE DATE <b>7-1-66</b>	
<b>HOSPITAL INSURANCE</b>	
<b>MEDICAL INSURANCE</b>	
SIGN  HERE 	

Front

1. Carry your card with you when you are away from home.
2. Let your hospital or doctor see your card when you require hospital, medical or health services under "Medicare."
3. Get in touch with your social security office if you have questions about your rights under "Medicare."
4. Your card is good wherever you live in the United States.




WARNING: Issued for the sole use of the holder designated hereon. Intentional misuse of this card is unlawful and will make the offender liable to penalty.

PROPERTY OF UNITED STATES GOVERNMENT.  
IF FOUND DROP IN NEAREST U.S. MAIL BOX.

Return To: **SOCIAL SECURITY ADMINISTRATION**  
Baltimore, Maryland 21235

FORM SSA-1966 (7-66)

Back

Health  Insurance	
<b>RAILROAD RETIREMENT BOARD</b>	
NAME OF BENEFICIARY <b>JOHN C. DOE</b>	
CLAIM NUMBER <b>A-000-00-0000</b>	SEX <b>MALE</b>
IS ENTITLED TO EFFECTIVE DATE <b>7-1-66</b>	
<b>HOSPITAL INSURANCE</b>	
<b>MEDICAL INSURANCE</b>	
SIGN  HERE 	

Front

1. Carry your card with you when you are away from home.
2. Let your hospital or doctor see your card when you require hospital, medical or health services under "Medicare".
3. Get in touch with your Railroad Retirement Board office if you have questions about your rights under "Medicare."
4. Your card is good wherever you live in the United States. For benefits in Canada, write to the Railroad Retirement Board.

WARNING: Issued for the sole use of the holder designated hereon. Intentional misuse of this card is unlawful and will make the offer liable to penalty.

PROPERTY OF UNITED STATES GOVERNMENT.  
IF FOUND DROP IN NEAREST U.S. MAIL BOX.

Return to: **RAILROAD RETIREMENT BOARD**  
844 Rush Street, Chicago, Illinois 60611

Form G-43 (2-66)

Back





District Office Address:

Date:

Dear \_\_\_\_\_:

Based on the information you have given to the Social Security Administration you will be eligible for hospital insurance benefits beginning (mo.) \_\_\_\_\_ (yr.) \_\_\_\_\_ and for supplementary medical insurance benefits beginning (mo.) \_\_\_\_\_ (yr.) \_\_\_\_\_. Your eligibility will continue for 60 days from the date shown at the top of this notice unless you are notified otherwise during the 60-day period.

To obtain medical services before you receive your card, show this letter to your hospital or doctor but keep the letter with you. This temporary notice of eligibility is to be used only by the person to whom it is addressed. Misuse is unlawful and will make the offender liable to a penalty.

This letter should be destroyed as soon as you receive your health insurance card or other notice concerning your eligibility.

Sincerely yours,

Robert M. Ball  
Commissioner of Social Security

## IMPORTANT

When services are provided on the basis of this notice, all bills or correspondence with an intermediary or the Social Security Administration should show the patient's social security claim number.







## Section 3550

DEPARTMENT OF  
HEALTH, EDUCATION, AND WELFARE  
SOCIAL SECURITY ADMINISTRATION

## EXHIBIT 2 A

INPATIENT HOSPITAL ADMISSION AND BILLING  
HOSPITAL INSURANCE BENEFITS—SOCIAL SECURITY ACTForm Approved  
Budget Bureau  
No. 72-R734

1. PATIENT'S LAST NAME		FIRST NAME	MI	2. HEALTH INSURANCE CLAIM NUMBER	
3. PATIENT'S ADDRESS (Street number, City, State, Zip Code)				4. DATE OF BIRTH	5. SEX <input type="checkbox"/> M <input type="checkbox"/> F
6. HOSPITAL NAME AND ADDRESS		7. PROVIDER NO.		9. NAME AND ADDRESS OF ATTENDING PHYSICIAN	
		8. MEDICAL RECORD NO.			
10. DATE OF THIS ADMISSION		11. NAME AND ADDRESS OF ANY INSTITUTION FROM WHICH DISCHARGED DURING LAST 60 DAYS (If this hospital, give dates of stay)			
12. PAYMENT SOURCE FOR CHARGES TO PATIENT <input type="checkbox"/> SELF OR FAMILY <input type="checkbox"/> BLUE CROSS BLUE SHIELD <input type="checkbox"/> PUBLIC AGENCY (Give name) <input type="checkbox"/> PRIVATE INSURANCE <input type="checkbox"/> EMPLOYER OR UNION <input type="checkbox"/> OTHER (Explain)					
13. PATIENT'S CERTIFICATION: AUTHORIZATION TO RELEASE INFORMATION AND PAYMENT REQUEST. I certify that the information given by me in applying for payment under Title XVIII of the Social Security Act is correct. I authorize release of all records required to act on this request. I request that payment of authorized benefits be made on my behalf.					
SIGNATURE (Patient or authorized representative) (Signature by mark must be witnessed)					DATE

14. ADMITTING DIAGNOSIS	EMPLOYMENT RELATED <input type="checkbox"/> YES <input type="checkbox"/> NO	If yes, give name and address of employer
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## REPORT OF ELIGIBILITY

A. Effective Date - Hospital Insurance			J. Open Item Information 1. Intermediary
B. Effective Date - Medical Insurance			
C. Hospital Days Remaining	Full	Coinsurance	
D. Medical Plan Deductible	<input type="checkbox"/> Met	<input type="checkbox"/> Not Met	
E. Remaining inpatient Deductible \$			2. Provider
F. Pints Remaining Blood Deductible			
G. ECF Days Remaining			
H. HHA Visits remaining	Hospital Insurance	Medical Insurance	
I. Psychiatric Days Remaining			3. Date Admitted
Remarks			
		4. Date Discharged	
Intermediary Approval			Date





## EXHIBIT 2 B

3550

INPATIENT PSYCHIATRIC OR TUBERCULOSIS HOSPITAL ADMISSION AND BILLING  
HOSPITAL INSURANCE BENEFITS - SOCIAL SECURITY ACTForm Approved.  
Budget Bureau  
No. 72-R732

1. PATIENT'S LAST NAME		FIRST NAME	MI	2. HEALTH INSURANCE CLAIM NUMBER	
3. PATIENT'S ADDRESS (Street number, City, State, Zip Code)				4. DATE OF BIRTH	5. SEX <input type="checkbox"/> M <input type="checkbox"/> F
6. HOSPITAL NAME AND ADDRESS		7. PROVIDER NO.		9. NAME AND ADDRESS OF ATTENDING PHYSICIAN	
		8. MEDICAL RECORD NO.			
10. ADMITTED TO ACTIVE CARE		11. NAME AND ADDRESS OF ANY INSTITUTION (including this institution) IN WHICH PATIENT RECEIVED INPATIENT CARE DURING LAST 60 DAYS (If this hospital, give dates of stay)			
12. NAME AND ADDRESS OF ANY PSYCHIATRIC OR TUBERCULOSIS INSTITUTION WHICH FURNISHED INPATIENT SERVICES AT ANY TIME DURING 90 DAY PERIOD PRECEDING EFFECTIVE DATE FOR HOSPITAL INSURANCE (If this hospital, give dates of stay)					
13. PAYMENT SOURCE FOR CHARGES TO PATIENT <input type="checkbox"/> SELF OR FAMILY <input type="checkbox"/> BLUE CROSS BLUE SHIELD <input type="checkbox"/> PUBLIC AGENCY (Give name) <input type="checkbox"/> PRIVATE INSURANCE <input type="checkbox"/> EMPLOYER OR UNION <input type="checkbox"/> OTHER (Explain)					
14. PATIENT'S CERTIFICATION: AUTHORIZATION TO RELEASE INFORMATION AND PAYMENT REQUEST. I certify that the information given by me in applying for payment under Title XVIII of the Social Security Act is correct. I authorize release of all records required to act on this request. I request that payment of authorized benefits be made on my behalf.					
SIGNATURE (Patient or authorized representative) (Signature by mark must be witnessed)					DATE
15. ADMITTING OR CURRENT DIAGNOSIS EMPLOYMENT RELATED <input type="checkbox"/> YES <input type="checkbox"/> NO (If yes, give name and address of employer.)					

## REPORT OF ELIGIBILITY

A. Effective Date - Hospital Insurance			J. Open Item Information 1. Intermediary
B. Effective Date - Medical Insurance			
C. Hospital Days Remaining	Full	Coinsurance	
D. Medical Plan Deductible	<input type="checkbox"/> Met	<input type="checkbox"/> Not Met	
E. Remaining Inpatient Deductible	\$		
F. Pints Remaining Blood Deductible			
G. ECF Days Remaining			2. Provider
H. HHA Visits Remaining	Hospital Insurance	Medical Insurance	
I. Psychiatric Days Remaining			
Remarks			3. Date Admitted
			4. Date Discharged
INTERMEDIARY APPROVAL			DATE





HOME HEALTH AGENCY  
REPORT AND BILLING

1. PATIENT'S LAST NAME		FIRST NAME		MI	2. HEALTH INSURANCE CLAIM NUMBER	
3. PATIENT'S ADDRESS (Street number, City, State, Zip Code)					4. DATE OF BIRTH	
					5. SEX <input type="checkbox"/> M <input type="checkbox"/> F	
6. HOME HEALTH AGENCY NAME AND ADDRESS			7. PROVIDER NO.		9. NAME AND ADDRESS OF ATTENDING PHYSICIAN	
			8. MEDICAL RECORD NO.			
10. DATE CARE STARTED		11. NAME AND ADDRESS OF INSTITUTION, IF ANY, CARING FOR CONDI- TION LATER REQUIRING HOME HEALTH SERVICES			12. VERIFIED DATES OF STAY IN ITEM 11 FROM TO	
13. DATE HOME HEALTH PLAN ESTABLISHED						
14. PAYMENT SOURCE FOR CHARGES TO PATIENT						
A. <input type="checkbox"/> SELF OR FAMILY C. <input type="checkbox"/> BLUE CROSS BLUE SHIELD E. <input type="checkbox"/> PUBLIC AGENCY (Give name)						
B. <input type="checkbox"/> PRIVATE INSURANCE D. <input type="checkbox"/> EMPLOYER OR UNION F. <input type="checkbox"/> OTHER (Explain)						
15. PATIENT'S CERTIFICATION: AUTHORIZATION TO RELEASE INFORMATION AND PAYMENT REQUEST: I certify that the information given by me in applying for payment under Title XVIII of the Social Security Act is correct. I authorize re-lease of all records required to act on this request. I request that payment of authorized benefits be made in my behalf.						
SIGNATURE (Patient or authorized representative) (Signature by mark must be witnessed)						DATE
16. DIAGNOSES						LEAVE BLANK
EMPLOYMENT RELATED A. <input type="checkbox"/> YES B. <input type="checkbox"/> NO (If yes, give name and address of employer.)						

REPORT OF ELIGIBILITY

A. EFFECTIVE DATE, HOSPITAL INSURANCE		J. OPEN ITEM	
B. EFFECTIVE DATE, MEDICAL INSURANCE		1. INTERMEDIARY	
C. DATE OF START OF CARE			
D. HOSPITAL INSURANCE VISITS AVAILABLE			
E. MEDICAL INSURANCE VISITS AVAILABLE			
F. LAST DISCHARGE DATE		2. PROVIDER	
G. MEDICAL PLAN DEDUCTIBLE <input type="checkbox"/> MET <input type="checkbox"/> NOT MET			
H. OUTPATIENT PSYCHIATRIC EXPENSE <input type="checkbox"/> MET <input type="checkbox"/> NOT MET		3. ADMITTED	
I. REMARKS:		4. DISCHARGED	
APPROVED BY		DATE	





PART A - NOTICE OF ADMISSION CODING SHEET

PREFIX	INTERMEDIARY NUMBER				PROVIDER NUMBER				TYPE QUERY						
II	IN	1	2	3	4	5	PN	0	5	0	0	0	1	TQ	I

CLAIM NUMBER HOLDER										INITIALS										CLAIM NUMBER									
CH	P	O	N	S						J	H	CN	0	0	0	0	0	0	0	0	0	0	B						

DATE OF ADMISSION				DATE OF BIRTH							
DA	MO.	DAY	YEAR	DB	MO.	DAY	YEAR				
0	2	1	2	6	7	0	1	1	2	9	2

FORM SSA-1577a (5-66)

3-147



## EXPLANATION OF PART A REPLY--EXHIBITS 6 - 10

Periods (.) in the replies are used as field separator characters. Individual replies will be separated by five blank lines. The last field in a line will not be followed by a period and a field will not be split between two lines.

Type of Reply Indication--Identifies the type of reply. (See § 3504 for various reply indications.)

Intermediary Number--The number assigned by SSA to the intermediary.

HI Claim Number--The beneficiary's Health Insurance claim number. It may be from 7 to 12 digits in length. Unused positions following the 7th digit will be blank.

Disposition Code--A code describing the reply; it may encompass caution signals, no record indications, questionable items, errors, etc. (See § 3504.A.7.)

Date of Admission or Date of Start of Care--This date as given in the query record that elicited reply. Month, Day, and Year, e.g., 081066.

Hospital Days Full Coverage--A maximum of 60 days less the number of covered days (up to 60) spent as a hospital inpatient during the most recent spell of illness.

Hospital Days Coinsurance--A maximum of 30 days of coinsurance coverage less the number of covered days over 60 spent as a hospital inpatient during the most recent spell of illness.

Psychiatric Days Available--A lifetime maximum of 190 days less the number of covered days used.

Extended Care Facility Days Available--A maximum of 100 days less the number of covered days spent in an extended care facility during the most recent spell of illness.

Home Health Agency Visits Available Part A--A maximum of 100 home health visits less the number of visits used since the last discharge from a hospital or extended care facility and covered under Part A.

Inpatient Hospital Deductible Part A--The applicable inpatient deductible (\$40.00 before 1969) less the amount of the inpatient deductible paid during the most recent spell of illness.



Part B Deductible Status--"1" if Part B deductible is met. "2" if Part B deductible is not met.

Blood Deductible Pints--Three pints of whole blood less the number of pints paid for or replaced during the most recent spell of illness.

Last Discharge Date--The date of the most recent discharge from a hospital or extended care facility. Month, Day, and Year, e.g., 091166.

Part A Effective Date--The month and year of entitlement to Part A benefits, e.g., 0766.

Part B Effective Date--The month and year of entitlement to Part B benefits, e.g., 0766.

Provider Number--This is a 6-digit number assigned by SSA to identify the provider.

Psychiatric Expense Incurred Status--"1" if maximum payable has been reached. "2" if maximum payable has not been reached.

Home Health Agency Visits Available Part B--A maximum of 100 home health visits less the number of visits used during the current calendar year and covered under Part B.

The following information identifies and describes the "Trailer" codes. The "Trailer" codes are preceded and succeeded by a period (.) except when the code is the first position of lines other than the first line. A line may begin with a "Trailer" code followed by a period (.)

<u>Trailer Code</u>	<u>Data</u>	<u>Field Length</u>
B	Name Correction	14
C	Health Insurance Claim Number Correction	12
D	Open Item Trailer	19
	(i.e. Intermediary Number 02241	5
	Separator Period	1
	Provider Number 240001	6
	Separator Period	1
	Admission Date	6

NOTE: More than one open item trailer may appear at the end of a reply message.

TYPE 1 - INPATIENT HOSPITAL OR EXTENDED CARE FACILITY REPLY -  
NO CORRECTION OR OPEN ITEM TRAILER

Position

1	Type of Reply Code (1)
3-7	Intermediary Number
9-20	HI Claim Number
22-23	Disposition Code
25-30	Date of Admission
32-33	Hospital Days Full Coverage
35-36	Hospital Days Coinsurance
38-40	Psychiatric Days Available
42-44	Extended Care Facility Days Available
46-48	Home Health Agency Visits Available Part A
50-53	Inpatient Hospital Deductible Part A
55	Part B Deductible Status
57	Blood Deductible Pints
59-64	Last Discharge Date
66-69	Part A Effective Date

Line #2

1-4 Part B Effective Date

Example:

1.01212.021102011D .01.082866.60.30.190.100.100.4000.2.3. .0766  
0766

NOTE: Last discharge date field is shown as blank since there  
has been no prior Part A utilization.





TYPE 1 - INPATIENT HOSPITAL OR EXTENDED CARE FACILITY REPLY -  
OPEN ITEM TRAILER

Position

1	Type of Reply Code (1)
3-7	Intermediary Number
9-20	HI Claim Number
22-23	Disposition Code
25-30	Date of Admission
32-33	Hospital Days Full Coverage
35-36	Hospital Days Coinsurance
38-40	Psychiatric Days Available
42-44	Extended Care Facility Days Available
46-48	Home Health Agency Visits Available Part A
50-53	Inpatient Hospital Deductible Part A
55	Part B Deductible Status
57	Blood Deductible Pints
59-64	Last Discharge Date
66-69	Part A Effective Date

Line #2

1-4	Part B Effective Date
6	Trailer Code (D)
8-12	Intermediary Number
14-19	Provider Number
21-26	Date of Admission

Example:

1.01212.031017395A .21.100266.60.30.190.100.100.4000.2.3. .0766  
 0766.D.02241.240001.080366



TYPE 1 - INPATIENT HOSPITAL OR EXTENDED CARE FACILITY REPLY -  
CORRECTED BENEFICIARY NAME

Position

1	Type of Reply Code (1)
3-7	Intermediary Number
9-20	HI Claim Number
22-23	Disposition Code
25-30	Date of Admission
32-33	Hospital Days Full Coverage
35-36	Hospital Days Coinsurance
38-40	Psychiatric Days Available
42-44	Extended Care Facility Days Available
46-48	Home Health Agency Visits Available Part A
50-53	Inpatient Hospital Deductible Part A
55	Part B Deductible Status
57	Blood Deductible Pints
59-64	Last Discharge Date
66-69	Part A Effective Date

Line #2

1-4	Part B Effective Date
6	Trailer Code (B)
8-21	Corrected Name of Beneficiary

Example:

1.01212.058097757A .02.071566.59.30.190.100.100.2000.2.3.070566.0766  
 0766.B.MAHONEY ,TA





TYPE 1 - INPATIENT HOSPITAL OR EXTENDED CARE FACILITY REPLY -  
CORRECTED HI CLAIM NUMBER AND OPEN ITEM TRAILER

Position

1	Type of Reply Code (1)
3-7	Intermediary Number
9-20	HI Claim Number
22-23	Disposition Code
25-30	Date of Admission
32-33	Hospital Days Full Coverage
35-36	Hospital Days Coinsurance
38-40	Psychiatric Days Available
42-44	Extended Care Facility Days Available
46-48	Home Health Agency Visits Available Part A
50-53	Inpatient Hospital Deductible Part A
55	Part B Deductible Status
57	Blood Deductible Pints
59-64	Last Discharge Date
66-69	Part A Effective Date

Line #2

1-4	Part B Effective Date
6	Trailer Code (C)
8-19	Corrected HI Claim Number
21	Trailer Code (D)
23-27	Intermediary Number
29-34	Provider Number
36-41	Date of Admission

Example:

1.02212.396320606	.21.102866.60.30.190.100.100.4000.2.3.	.0766
0766.C.396320606A	.D.02241.240001.080366	





TYPE 2 - HOME HEALTH CARE REPLY - NO CORRECTION OR OPEN ITEM  
TRAILERS

Position

1	Type of Reply Code (2)
3-7	Intermediary Number
9-20	HI Claim Number
22-23	Disposition Code
25-30	Date of Start of Care
32-34	Home Health Agency Visits Available Part A
36-38	Home Health Agency Visits Available Part B
40	Part B Deductible Status
42	Psychiatric Expense Incurred Status
44-49	Last Discharge Date
51-54	Part A Effective Date
56-59	Part B Effective Date

NOTE: The correction trailer for HI claim numbers and name, and the open item trailer appear in this message on line 2 as they appear in the type 1 replies.

Example:

2.01212.484100337 D .02.101066.092.100.2.2.093066.0766.0766



TYPE 3 REPLY - RECORD NOT IN FILE ON BASIS OF EITHER HI CLAIM NUMBER  
OR NAME SUBMITTED (SSA is investigating, a type 1  
or 2 reply will follow.)

Position

1	Type of Reply Code (Type 3)
3-7	Intermediary Number
9-20	HI Claim Number
22-23	Disposition Code
25-35	Surname
36	Comma
37-38	First Initial, Middle Initial or Blank if not Middle Initial
40	Query Code
42-47	Provider Number
49-54	Date of Admission or Date of Start of Care

TYPE 4 REPLY - INITIAL EDIT REJECT

Position

1	Type of Reply Code (Type 4)
3-7	Intermediary Number
9-20	HI Claim Number
22-23	Surname
33	Comma
34-35	First Initial, Middle Initial
37	Query Code
39-44	Provider Number
46-51	Date of Admission or Date of Start of Care
53-58	Date of Birth

NOTE: The field or fields that caused the Edit Reject  
will be followed by an (\*) instead of a (.).





## PART B - INQUIRY CODING SHEET

PREFIX	INTERMEDIARY NO.				INTERMEDIARY CONTROL NO.				TYPE QUERY			
II	IN	1	2	3	4	5	IC			132	TQ	I

CLAIM NUMBER HOLDER										SEX		CLAIM NUMBER																
CH	A	R	M	E	N	D	A	R	I	Z	B	B	M	F	UNK	1	2	3	CN	0	0	0	0	0	0	0	0	B

JANUARY THROUGH SEPTEMBER

DATE FIRST INCURRED		REASONABLE CHARGE		REASONABLE PSYCH. CHARGE	
MO.	YEAR				
SI	0967	RC	2000	PC	

OCTOBER THROUGH DECEMBER

DATE FIRST INCURRED		REASONABLE CHARGE		REASONABLE PSYCH. CHARGE	
MO.	YEAR				
CD	1067	CC	3000	CP	

FORM SSA-1577 (5-66)

U. S. GOVERNMENT PRINTING OFFICE 1966 O - 218-682





EXAMPLES OF PART B ARS MESSAGE REPLIESTYPE 6 REPLIES - PART B DEDUCTIBLE/PSYCHIATRIC STATUS REPLYExample 1:

6.01212.049077395A .01.0866.081201.5000  
A.1234567891.C.049707395A  
G.CONSUELLA G DAVIS &, PIERINA F ARSENA, GDNS OF,  
MARIA C BASILE,59 WRIGHT ST,NEW BERLIN N Y

Position

1	Type of Reply Code (6)
3-7	Intermediary Number
9-20	HI Claim Number
22-23	Disposition Code (01--gives unqualified data)
25-28	Part B Effective Date
30-35	Date of Birth
37-40	Part B Deductible To Be Met

Line #2 if Needed

1	Part B Trailer Record Code (A)
3-12	Intermediary Control Number
14	Second Trailer Record Code (C)
16-27	HI Claim Number Correction

Line #3 if Needed

1	Part B Trailer Record Code (G)
3-69	First Line of Representative Payee Information (Part A Intermediaries Disregard.)

Line #4 if Needed

1-69	Second Line of Representative Payee Information (Part A Intermediaries Disregard.)
------	---

Example 2:

6.01212.100141628B .01.0766.102081.5000  
B.MCCADDEN ,LJ.D.50000

Position

1	Type of Reply Code (6)
3-7	Intermediary Number
9-20	HI Claim Number
22-23	Disposition Code
25-28	Part B Effective Date
30-35	Date of Birth
37-40	Part B Deductible

Line #2 if Needed

1	Part B Trailer Record Code (B)
3-16	Name Correction
18	Part B Trailer Record Code (D)
20-24	Noninpatient Psychiatric Expense Status (PART A INTERMEDIARIES DISREGARD THIS ITEM.)

EXAMPLE OF PART B ARS MESSAGE REPLY

TYPE 3 REPLY - QUERY ACKNOWLEDGMENT. SSA is unable to locate the record based on the HI claim number and/or name given in the query. SSA is investigating; type 4 or 6 reply will follow.

3.01212.387129686B .00.MEYER ,AW.I.1.0766.034265

Position

1	Type of Reply Code (3)	
3-7	Intermediary Number	
9-20	HI Claim Number	
22-23	Disposition Code	
25-35	Surname	
36	Comma	
37-38	First Initial, Middle Initial	
40	Query Code (This is a repeat of the query code furnished in the query.)	
42	Sex	
44-47	Month Service Incurred	
49-54	Reasonable Charges	
56	Part B Trailer Record Code (A)	)These would be added
58-67	Intermediary Control Number	)if the intermediary control number was furnished in the query.





EXAMPLE OF PART B ARS MESSAGE REPLY AS IT MAY APPEAR ON HARD COPY  
AT THE RECEIVING STATION

TYPE 4 REPLY - REJECTION OF QUERY BY SSA DURING INITIAL QUERY EDIT

4.01212.396031217D .LANGE ,RT.I.1.0866.00750A\*10000  
 A.1296066109

Position

1	Type of Reply Code (4)
3-7	Intermediary Number
9-20	HI Claim Number
22-32	Surname
33	Comma
34-35	First Initial, Middle Initial
37	Query Code (This is a repeat of the query code given in the query.)
39	Sex
41-44	Month Service Incurred
46-51	Reasonable Charge
52	*Denotes Query Transmission Error in Preceding Field
53-57	Reasonable Charges Noninpatient Psychiatric (PART A INTERMEDIARIES DISREGARD THIS ITEM.)

Line #2 if Needed

1	Trailer Record Code (A)	) Shown when the
3-12	Intermediary Control Number	) intermediary control number was furnished in the query.





EXAMPLE OF PART B MESSAGE REPLY

TYPE 4 REPLY - REJECTION OF QUERY BY SSA DURING INITIAL QUERY EDIT  
 (For example, when a letter appears in a field that should be all numbers.)

4.01212.375123456HB .BASILE ,MC.I.2.0766.010150.05000  
 1066.005000.02G50\*A.1234509876

Position

1	Type of Reply (4)
3-7	Intermediary Number
9-20	HI Claim Number
22-32	Surname
33	Comma
34-35	First Initial, Middle Initial
37	Query Code (This is a repeat of the query code given in the query.)
39	Sex
41-44	Month Service Incurred
46-51	Reasonable Charge
53-57	Reasonable Charges Noninpatient Psychiatric (PART A INTERMEDIARIES DISREGARD THIS ITEM.)

Line #2 if Needed

1-4	Month Service Incurred (Oct.-Dec.)
6-11	Reasonable Charges (Oct.-Dec.)
13-17	Reasonable Charges Noninpatient Psychiatric (Oct.-Dec.) (PART A INTERMEDIARIES DISREGARD THIS ITEM.)
18	The Asterisk (*) Denotes Query Transmission Error in Preceding Field
19	Trailer Record Code (A)
21-30	Intermediary Control Number



3800 - Transmittal and Maintenance of  
Claims Records

3600 - Bill Review

3700 - Payment and Postpayment  
Procedures





# CHAPTER VII

## BILL REVIEW

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## 3600. GENERAL

When services have been furnished, the provider will forward the appropriate billing form with the necessary attachments to the intermediary who is to review the documents and determine the amount payable to the provider. The intermediary's certification of payment is based upon the data in the billing form, attachments to the billing form, and information supplied by the Social Security Administration in response to the notice of admission and other queries.

The billing forms requiring Part A intermediary review include:

- A. SSA-1453 - Inpatient Hospital Admission and Billing
- B. SSA-1485 - Inpatient Psychiatric or Tuberculosis Hospital Admission and Billing
- C. SSA-1483 - Outpatient Hospital Billing
- D. SSA-1487 - Home Health Agency Report and Billing
- E. SSA-1478 - Extended Care Admission and Billing (being devised)

The identifying data, e.g., beneficiary's name, health insurance claim number, etc. is arranged in similar order on all forms. This data is essential for identifying the beneficiary on Social Security Administration central records and to establish his entitlement to benefits under Part A and/or Part B. (See Chapter VI.) The billing portion of the forms solicit necessary information to identify services and items furnished as well as charges necessary to make reimbursement determinations, i.e., interim payments and annual settlements. The interim payment consists of the estimated reasonable costs less the applicable deductibles and coinsurance. For the annual settlement, provider departmental totals will be accumulated giving a basis for judgement as to the provider costs and charge statements when providers are reimbursed on an RCC method. In addition to the foregoing, the billing forms serve to furnish program and operating statistics.

The signed statements of the beneficiary with respect to certification, release authorization, and request for payment are an essential part of the billing form. These statements, however, may be on any writing attached to the file.

### 3601. AUTHORIZED PROVIDER SIGNATURES AND LISTINGS

The signature of the authorized provider representative on the billing form attests that the required certification or recertifications are in the provider's file to support the request for payment (stamped signatures are not acceptable). This statement must accompany the claims material when it is not executed on the billing form. The statement on the billing form, or on attachments, that the certification and recertifications are on file, will generally be accepted by the intermediary for purposes of individual billing review.

Each provider should submit to its Part A intermediary a listing of officials it has authorized to sign and certify bills and supporting statements. The listing should be kept current and should be used by the intermediary for reference when a question arises about the validity of a bill.

### 3602. USE OF LEDGER SHEETS

If the provider and the intermediary agree, the provider may use columnar ledger sheets to report its services and charges. In such cases, the provider need not complete the statement of services, except for accommodation and blood entries, where appropriate. Services which are not covered must be either itemized on the ledger or shown in the "Noncovered" column of the billing form. When the hospital does not fully itemize charges on the form itself, it must be done by the intermediary since only billing forms are transmitted to the Social Security Administration.

### 3603. DESIGN OF INPATIENT HOSPITAL ADMISSION AND BILLING FORMS BY HOSPITALS

Some hospitals using electronic data processing equipment may prefer to design their own inpatient admission and billing form as a continuous feed form that can be printed by their electronic data process.

This is permissible provided such a form closely follows the format of the standard form. Such things as wording, numbering of items, placement of items, and placement of columns should be identical to that of the standard form. The only substantial flexibility would be in spacing, size of margins, length of the form, etc., so the form would be compatible with the electronic data processing system.

Since it is not practical for a beneficiary to sign a mechanically prepared form, it is also permissible for hospitals to reproduce a patient's signature form. The wording on the form must be identical with that on the standard form, e.g., item 13 of form SSA-1453. The

signature form must be signed by the patient and attached to the hospital's billing form. The signature of the hospital representative, however, should be on the billing form itself.

Any form a hospital designs must be submitted to the Social Security Administration for approval. Such forms designs should be sent to:

Bureau of Health Insurance  
Division of Methods and Procedures  
4-R-5 Operations Building  
6401 Security Boulevard  
Baltimore, Maryland 21235

#### 3604. BILL REVIEW TECHNIQUES

The intermediary is responsible for a review of the total billing form. Bill review techniques developed through the intermediary's experience will be used and/or adapted for operations applicable to this program. The skill and judgement of the intermediary are relied upon in making correct payment under the health insurance program. It is expected that claims evaluation and review experience with the program will serve to provide a basis for the identification of troublesome conditions and situations. As these trouble areas are analyzed, review techniques and procedures can be refined.

The following are some basic evaluation techniques and may be supplemented by others normally used by the intermediary in its own review operations:

A. Reconciliation of diagnoses with surgical or other procedures and with the pattern of acceptable or consistent related services rendered in the hospital.

B. Recognition of incomplete, inconsistent, or duplicative entries, e.g., surgical procedures without corresponding consistent entries such as an operating room and anesthesia; the contrary situation, where there is an entry for an operating room and/or anesthesia recorded, but no surgical procedure is shown.

C. Charges appear unreasonable.

D. Identification of personal comfort or other non-covered services.

E. Identification of potential workmen's compensation payments.



F. Identification of diagnoses or procedures suggesting that services would not be covered, e.g., cosmetic surgery.

When additional information must be obtained to resolve a question on a billing form, intermediaries should be guided by their experience in deciding how the additional information can best be secured.

Corrections on the billing forms may be simply made by additions or deletions. Noncovered charges may only need to be relocated on the form and the original entry deleted where appropriate. Changes on the billing form should be made neatly so that legibility will be assured.

#### 3605. RELEASE OF CARRIER COPIES OF BILLING FORM

The copy of the hospital billing form (inpatient and outpatient) designated "Carrier Copy" is to be sent to the Part B carrier upon completion of the billing process. The Carrier Copy will be sent to the carrier servicing the hospital's area in every case where the SSA-1554 (Provides Billing For Patient Services By Physicians) accompanies the billing form and the beneficiary is not identified as a Railroad Retirement Beneficiary. (Railroad beneficiaries may be identified by the health insurance claim number, which will be either a six or nine digit number with one or more letter prefixes.) Where a railroad retirement beneficiary is identified, the SSA-1554 and the carrier copy is to be forwarded to the Travelers Insurance Company which is the carrier for such beneficiaries. Where an SSA-1554 does not accompany the hospital billing the carrier copy should be sent to the carrier servicing the address of the physician shown in item 9 of the billing form or Travelers Insurance Company if the beneficiary is a Railroad Retirement beneficiary.

The Carrier Copy of these forms is used by the Part B intermediary to supplement and assess a Part B bill for physician's services that it may process. It may, for example, be useful to determine whether a bill for surgery is consistent with the information available about the period of hospitalization and the kind of treatment the patient received. It may also be used to assist in a determination of reasonable charges for salaried physicians. When a patient submits receipted bills to the carrier, the carrier copy of the hospital billing form will provide complete diagnoses if the receipted bill lacks this information.

3606. COPIES OF APPROVED BILLING FORMS FOR PUBLIC WELFARE AGENCIES  
If the item "Payment Source for Charges to Patient" indicates that some of the charges will be paid by welfare, the intermediary is to prepare and send a copy of the approved provider services billing form to the welfare agency shown on the form. (The copy to welfare should include reimbursement amount or computation and intermediary signature.) Procedures for handling cases where welfare requires additional information from the intermediary will be developed by the welfare agencies and the intermediaries.

3607. PART A INTERMEDIARY HANDLING OF FORM SSA-1554, PROVIDER  
BILLING FOR PATIENT SERVICES BY PHYSICIANS

Hospitals billing for hospital-based physicians will complete form SSA-1554, Provider Billing for Patient Services By Physicians. They will transmit this form to Part A intermediaries in situations where they are concurrently transmitting an inpatient or outpatient bill. When an inpatient or outpatient bill is not being transmitted the hospital will send the SSA-1554 directly to the Part B carrier.

When the Part A intermediary receives the hospital bill with a form SSA-1554, it will hold the SSA-1554 until the hospital billing is processed to completion and then attach the SSA-1554 to the Carrier Copy of the hospital billing form to the appropriate carrier (See § 3605). The carrier will review the SSA-1554 and make the necessary payment.

3608. GUARANTEE OF PAYMENT DETERMINATIONS

A hospital bill involving guarantee of payment (See § 3405 ff.) is to be accompanied by information sufficient to justify payment under this provision. If such information is not included with the bill, it should be requested from the hospital. The information on the billing form and the explanation is to be evaluated along the following guidelines:

A. Covered Services--The services shown on the bill must be within the scope of covered services.

B. Acted Reasonably--The hospital must establish that it acted reasonably in assuming that the patient's inpatient days had not been or were about to be exhausted. A decision that a hospital had or had not acted reasonably is to be made by evaluating the accompanying information furnished by the hospital. If this information justifies the hospital's assumption that coverage continued, then this requirement will have been met.



"Acted reasonably" will be found if the hospital attempted to ascertain the extent of the beneficiary's entitlement to inpatient hospital services by:

1. Asking the beneficiary or other person if the beneficiary received inpatient services in a hospital or extended care facility within the past 60 days; and

2. If such prior institutionalization is indicated, requesting the necessary additional information from the beneficiary or other person to determine the number of days of inpatient hospital services, if any, remaining in the current spell of illness.

C. Good Faith--If the hospital is determined to have acted reasonably in accordance with the criteria shown in B above, it will generally be presumed to have acted in good faith in assuming the individual was entitled to payment for hospital services unless the facts indicate otherwise. There would be an absence of good faith if the hospital furnished services under circumstances in which it had or should have had substantial doubt that coverage existed. Under such circumstances the hospital cannot qualify for payment under this provision.

D. Refund Made--If a portion of the bill has been paid by or on behalf of the patient, such payment must be refunded (other than the deductible and coinsurance amounts).

#### 3609. OUTPATIENT HOSPITAL SERVICES WHICH ARE TREATED AS INPATIENT HOSPITAL SERVICES

When an individual is furnished outpatient hospital services and is thereafter admitted as an inpatient of the same hospital before midnight of the next day, the outpatient hospital services furnished him are treated as inpatient services. The day on which he is formally admitted as an inpatient is counted as the first inpatient day.

#### 3610. INPATIENT BILLING AFTER EXHAUSTION OF BENEFITS

The benefit days available to a beneficiary depend on the status of his prior utilization of services during this "spell of illness."

The days that the beneficiary spends in the hospital after his 90 benefit days have been exhausted must be reported by the hospital so that the intermediary and the Social Security Administration will know when a spell of illness ends.



The information submitted on a billing form after benefits have been exhausted is limited to identifying information, critical dates, and essential statistical data.

Items 1, 2, 4, 7, 10, 12, 15, 16, 17 (line 0), 22, and 23 are the only items required on the Form SSA-1453, Inpatient Hospital Admission and Billing. Items 1, 2, 4, 7, 10, 13, 16, 17, 18 (line 0), 24, and 25 should be completed on Form SSA-1485, Inpatient Psychiatric or Tuberculosis Hospital Admission and Billing.

The hospital detaches the two admission copies and sends the top three copies of the form to the intermediary in the usual manner. Only one billing form need be completed for the period after benefits are exhausted, regardless of the length of time involved. This form may be completed after discharge or death.

The intermediary should review the identification items in accordance with regular review procedures and verify that benefits are, in fact, exhausted. Items 17 (line 0) or 18 (line 0) on forms SSA-1453 and SSA-1485 respectively, do not lend themselves to review. However, they should be checked to the extent of verifying that an entry is shown. Items 22 and 23 of the SSA-1453 and items 24 and 25 of the SSA-1485 should similarly show an entry and must be obtained where not shown.

The reviewing intermediary representative should affix his name in item 27 and also show the date signed. These forms should be transmitted under separate batch in accordance with § 3803.

3611. DISCHARGES ON PATIENT'S FIRST DAY OF ENTITLEMENT OR HOSPITAL'S FIRST DAY AS A PARTICIPATING PROVIDER

Where a patient who is admitted prior to the first date of his entitlement is discharged from a participating hospital on the first day of his entitlement, the day of discharge will be treated as a regular day of discharge; that is, an accommodations charge will not be allowed. However, ancillary services provided on that day will be covered. Although a day of utilization will not be charged a beneficiary, a spell of illness will be started and charges applied against the deductible as appropriate.

To assure proper processing of these cases, the inpatient billing form, SSA-1453, and the inpatient psychiatric or tuberculosis billing form, SSA-1485 should show the actual date of admission in item 10 of these forms. In the "Statement Covers Period" items (item 18 of the SSA-1453 and item 19 of SSA-1485) the date of discharge should be shown in both the "From" and "To" entries. In the "Total Days" items (item 19 of the SSA-1453 and item 20 of the SSA-1485) show "0."

In these particular instances any interim payment is to be computed on the basis of 85 percent of ancillary charges less the deductible amounts.

The same policy as described above will be governing in cases where an entitled individual in a noncovered stay in a nonparticipating hospital is discharged on the first day the hospital becomes a participating hospital.

#### 3612. AMBULANCE SERVICE

Ambulance service is covered under medical insurance. Whether the service is furnished to an inpatient or an outpatient, it should be billed on the Outpatient Hospital Billing form as a medical plan charge.

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DEPARTMENT OF  
HEALTH, EDUCATION, AND WELFARE  
SOCIAL SECURITY ADMINISTRATION

**INPATIENT HOSPITAL ADMISSION AND BILLING**  
**HOSPITAL INSURANCE BENEFITS—SOCIAL SECURITY ACT**

Form Approved  
Budget Bureau  
No. 72-R734

1. PATIENT'S LAST NAME			FIRST NAME		MI	2. HEALTH INSURANCE CLAIM NUMBER			
3. PATIENT'S ADDRESS (Street number, City, State, Zip Code)						4. DATE OF BIRTH		5. SEX <input type="checkbox"/> M <input type="checkbox"/> F	
6. HOSPITAL NAME AND ADDRESS				7. PROVIDER NO.		9. NAME AND ADDRESS OF ATTENDING PHYSICIAN			
				8. MEDICAL RECORD NO.					
10. DATE OF THIS ADMISSION			11. NAME AND ADDRESS OF ANY INSTITUTION FROM WHICH DISCHARGED DURING LAST 60 DAYS (If this hospital, give dates of stay)						
12. PAYMENT SOURCE FOR CHARGES TO PATIENT									
<input type="checkbox"/> SELF OR FAMILY			<input type="checkbox"/> BLUE CROSS BLUE SHIELD			<input type="checkbox"/> PUBLIC AGENCY (Give name)			
<input type="checkbox"/> PRIVATE INSURANCE			<input type="checkbox"/> EMPLOYER OR UNION			<input type="checkbox"/> OTHER (Explain)			
13. PATIENT'S CERTIFICATION: AUTHORIZATION TO RELEASE INFORMATION AND PAYMENT REQUEST. I certify that the information given by me in applying for payment under Title XVIII of the Social Security Act is correct. I authorize release of all records required to act on this request. I request that payment of authorized benefits be made on my behalf.									
SIGNATURE (Patient or authorized representative) (Signature by mark must be witnessed)								DATE	
14. ADMITTING DIAGNOSIS						EMPLOYMENT RELATED <input type="checkbox"/> YES <input type="checkbox"/> NO		If yes, give name and address of employer	
15. DISCHARGE DIAGNOSES OR CURRENT DIAGNOSES (Primary illness and secondary or complicating illnesses)								Do not use this space	
16. SURGICAL PROCEDURES (Related to primary illness and other—Show date of each)									
17. STATEMENT OF SERVICES RENDERED				TOTAL CHARGES		NON-COVERED CHARGES		18. STATEMENT COVERS PERIOD FROM TO	19. TOTAL DAYS
ACCOMMODATION		DAYS		RATE					
A. 1-Bed									
B. 2-3-4 Bed									
C. 5 or more Beds									
D. Intensive Care									
E. Self Care									
F. WHOLE BLOOD	PINTS FURNISHED	NOT REPLACED	CHARGE PER PINT						
G. Operating Room									
H. Pharmacy									
I. Laboratory									
J. Radiology									
K. Medical, Surgical and Central Supplies									
L. Anesthesia									
M. Inhalation Therapy									
N. Other (Describe)									
O. TOTALS									
P. Inpatient Deductible									
Q. Blood deductible		Pts. @							
R. Coinsurance									
S. TOTAL DEDUCTIONS									
I certify that the required physician's certification and recertifications are on file.									
26. SIGNATURE OF HOSPITAL REPRESENTATIVE				DATE FORWARDED		27. APPROVED BY		DATE	

3620. REVIEW OF INPATIENT HOSPITAL ADMISSION AND BILLING  
FORM SSA-1453

Items 1-14 provide the necessary identification, and admission data as well as information which will alert intermediaries to possible noncovered stays or workmen's compensation involvement.

Items 15-27 provide diagnoses, surgical procedures, service and billing data. The intermediary should carefully review the billing form with respect to both the admission data and the billing entries. The following discusses how the hospital is to complete the various items on this form which must be reviewed by the intermediary.

Item 1: Patient's Identification.--The patient's name will be shown with the last name first, but otherwise should be the same as that shown on his health insurance card.

Item 2: Health Insurance Claim Number.--The health insurance claim number should be checked at the time the admission data is received (See § 3504). The health insurance number should also be checked against the SSA reply to the notice of admission and corrections made as appropriate.

Item 3: Patient's Address.--The patient's mailing address should be shown in this item. The intermediary will not normally be required to review this item.

Items 4 and 5: Date of Birth and Sex.--The date of birth should be shown in item 4. However, the date of birth may not be shown if it is not available after the provider has made a reasonable effort to obtain it (See § 3507.8). Six-digit numbers are used for the date of birth, e.g., 01/02/95 for January 2, 1895. This information is provided to assist in identifying the patient and the sex designation should be reviewed in conjunction with items 14, 15, 16, diagnoses and surgical procedures to identify inconsistencies.

Items 6, 7, and 8:--Hospital and Medical Record Identification.--The name and address of the hospital and the hospital's health insurance provider number should be entered. These items may have been preprinted on all copies of the hospital's supply of these forms. The intermediary should check the accuracy of these items.

The patient's medical record in item 8 may be shown by the hospital if the hospital assigns one and it is needed by the hospital for association and reference purposes. The intermediary need not review this item.

- Item 9: Attending Physician.--The name and address of the attending physician should be shown. The name should be that of the physician who would normally be expected to certify and recertify the medical necessity of the hospital stay. If this item is omitted, it need not be obtained unless this information is needed to properly route the "Carrier Copy" of the form. (See § 3605.)
- Item 10: Date of This Admission.--The date of this admission should be shown in six-digit numbers each time a billing is submitted, e.g., 07/15/66. The actual date of admission should be shown even if before the effective date of entitlement to hospital insurance.
- Item 11: Prior Stay Information.--The name and address of any hospital or extended care facility from which the patient was discharged as an inpatient within the last 60 days before the present admission. If the prior stay was in the same hospital from which the admission notice is initiated the dates of stay will be shown. (See § 3520 for instructions on verifying the prior inpatient stay.)
- Item 12: Payment Source.--The hospital will show all sources that will pay amounts of the bill which cannot be paid for by the health insurance program. If a State public welfare agency will pay or has paid for such amounts, the name and address of the agency will be entered.
- Item 13: Patient's Certification and Payment Request.--This item should have the patient's signature, or the signature of someone filing on behalf of the patient. Where someone files on behalf of the patient, an accompanying statement should be attached explaining the relationship of the signatory to the patient and the circumstances that made it impracticable for the patient to sign. (See § 3302.)

Where the patient's signature is by mark, the mark must be witnessed by someone who knows him. The witness's name and address would be shown.

If the bill submitted, however, is a subsequent bill in connection with the same hospital admission, this item need not be completed. Similarly, if the billing is submitted for purposes of satisfying § 3610, Inpatient Billing After Exhaustion of Benefits, no signature need be shown.



- Item 14: Admitting Diagnosis --The admitting diagnosis as furnished by the physician to the hospital is provided for use in reviewing admission notices, where applicable, so that the intermediary may be alerted to the possibility of non-covered services. An essential part of this item is the information solicited regarding whether or not the condition was work-related. (See § 3409 ff. for a description of the necessary considerations required in handling workmen's compensation involvement.)
- Item 15: Discharge Diagnoses or Current Diagnoses--The discharge diagnoses should reflect information contained in the patient's medical record relating to all conditions causing the current episode of hospitalization. If two or more diagnoses are shown the one shown first should be the most significant of the conditions. The first diagnosis should show "primary" in parenthesis next to the entry. The diagnoses should be in accordance with recognized nomenclature, e.g., Current Medical Terminology, Standard Nomenclature of Diseases and Operations. If no diagnoses are shown, this information should be obtained from the hospital prior to payment and the appropriate entry made in this item. This item should be reviewed in conjunction with item 17 and may also serve to alert the intermediary to possible noncovered services.
- Item 16: Surgical Procedures--Surgical procedures performed during this billing period should be shown as entered in the patient's medical record. The first procedures listed should be related to the primary diagnosis. Surgical procedures should be specified in detail using recognized nomenclature such as that used in Current Medical Terminology, Standard Nomenclature of Diseases and Operations, etc. For the purposes of this item, surgery includes incision, excision, amputation, introduction, endoscopy, repair, destructions, suture and manipulations. This item should be reviewed in conjunction with item 17 and may alert the intermediary to possible noncovered services or omissions, e.g., no operating room charges are shown on the bill.
- Item 17: Statement of Services--All charges should be shown, (See § 3602 where ledger sheets are used.) Where the hospital has more departments than shown on the form, the charges should be combined, where appropriate, for purposes of completing the form. Any charges which cannot be applied to one of the items shown should be described in 17N-Other.

All charges - covered and noncovered - should be shown in the "Total Charges" column. Charges for noncovered services and items, except for the services of hospital-based physicians, are itemized in the "Noncovered Charges" column. A statement will be attached by the hospital where it is necessary to explain an item.

The amounts paid to a provider of services under the hospital insurance plan, subject to the deductible and coinsurance provisions, should be the estimated reasonable cost of the services. The intermediary is responsible for checking the accuracy of the total charges, estimated costs, and deductions.

#### Accommodation

- A. One-Bed--Where a patient needed a private room for medical reasons one copy of the SSA-1484, Explanation of Accommodation Furnished (See § 3635) should be attached to explain the medical necessity for such accommodations. The customary charge for a one-bed accommodation in the "rate" column should be shown and the "Total Charges" column will be completed.

If the patient was in a one-bed accommodation for other than medical reasons, payment cannot be made for more than the most prevalent two, three, or four-bed accommodation rate. In such cases an SSA-1484 will not be required and the charge for the one-bed accommodation should be entered in the "rate" column. The difference between the total one-bed room charges and the accommodations charges which would have been made if the patient had occupied a two-, three-, or four-bed room (at the most prevalent rate for such a room at the time of admission) should be shown in the "Noncovered Charges" column.

- B. Two-, Three-, or Four-Bed--If the patient occupied semi-private accommodations (two-, three-, or four-bed room) the number of days and the actual daily rate for the accommodations should be shown.
- C. Five or More Beds--Under the hospital insurance program, payment is made for semiprivate accommodations (two-, three-, or four-bed room). If the patient is assigned to a room with five or more beds, the hospital should complete



Form SSA-1484, Explanation of Accommodations Furnished, in duplicate, explaining the reasons for this accommodation, and these forms are attached to the billing form. If the patient requested that assignment, only one copy of the SSA-1484 is necessary. Where the patient requested a five or more bed assignment, or the reason for assignment is one that the intermediary can approve, the reimbursement will be made for the reasonable costs of the actual accommodation furnished. However, where the ward accommodation was provided not at the patient's request, nor for a reason which the intermediary can approve, payment will be made, at the end-of-the-year settlement, on the basis of the reasonable cost of semiprivate accommodations minus the difference between the hospital's customary charge for semiprivate accommodations and its customary charge for ward accommodations. In either case, the customary ward charge should be shown in the "Rate" column on the billing form. But when the ward accommodation was not requested by the patient or approved by the intermediary, the hospital should show its customary charge for semiprivate accommodation at the most prevalent rate at the time the accommodation was made, on the form SSA-1484, so that the intermediary can compute the payment due.

If the Hospital has only ward accommodations, the actual rate should be used for accommodations furnished. No supplemental statement is necessary.

See § 3635 for a full description of the Explanation of Accommodations Furnished form.

- D. and E. Intensive Care and Self-Care--The number of days the patient was in an intensive or self-care unit, applicable rate, and total charges should be shown.

The total number of days in the various accommodations shown on the form should equal the number of days shown in item 18, "Statement Covers Period." Where some of the days cannot be paid for because benefits were exhausted before discharge or death, charges for days after benefits were exhausted should be shown in "Noncovered Charges."

- F. Whole Blood--This item should reflect the pints of whole blood furnished, the number of pints not replaced, and the charge per pint of such blood. The charge per pint entry should reflect the cost of such blood excluding charges for administering the blood.



The "Total Charges" column will show the combined amount of the cost for pints not replaced and the charges for administering the blood.

- G. and H. General--Item G includes recovery room and item H includes intravenous solution.

Where items and services are furnished which are more expensive or in excess of the services covered by the program, the difference between the amount customarily charged for such services requested and the amount customarily charged for covered services should be shown as noncovered charges. An example of this would be luxury meals at extra cost.

- O. Totals--The total charges and the total noncovered charges should be shown.
- P. Inpatient Deductible--The amount of the deductible which is applicable is shown on the **reply** to the Notice of Admission. The amount to be shown in this item (in the "Noncovered Charges" column), is \$40 unless the deductible has been met in full or in part. Where the full deductible has not been met, the remaining deductible to be met should be shown. The only exception to this is where the total charge shown in item O minus any physicians' services included in that total charge, is less than the remaining deductible to be met. Where this is the case, the difference between the total charges and the physicians' services should be shown in this item:

Example: The beneficiary has met no part of the deductible. However, the total charge (item O) is \$42 and the charge for physicians' services included in the \$42 is \$5. Therefore, \$37 should be shown in item P.

- Q. Blood Deductible--Where whole blood has been furnished to the patient (Item F) and a remaining blood deductible is shown on the **reply** to the Notice of Admission, the number of pints of the deductible remaining should be shown in this item as well as the cost of the blood per pint (excluding the cost for administering the blood.) The cost of the blood per pint should be multiplied by the number of pints and the sum shown in the "Noncovered Charges" column.

R. Coinsurance--The coinsurance days are the 61st day through the 90th day. The number of coinsurance days should be multiplied by \$10 and the sum shown in the "Noncovered Charges" column.

S. Total Deductions--The total of any amount appearing in items P. through R.

Item 18: Statement Covers Period--The beginning and ending days of the period covered by the bill should be shown. The beginning date should be no earlier than the first day of the beneficiary's date of entitlement even though the date of admission in item 10 may be before that date. Where the patient was admitted before July 1, 1966, show 07/01/66 in the "From" item. In the "To" item, show the date of death or discharge.

Where the patient was still in the hospital, the last day of the period being reported on the bill will be shown, whether or not this last day was a day of covered services. (See § 3610 for completion of forms where benefit days are exhausted.)

Where inpatients of a hospital leave the hospital for planned leaves of absence or where they are absent without leave, the following rules apply in determining which days are to be counted as inpatient days.

a. Patient Does Not Return to Hospital by Midnight of the Same Day--Where an inpatient leaves a hospital on a given day and does not return by midnight of the same day, such day is treated as a day of discharge.

b. Patient Returns to Institution--The day on which a patient returns to the hospital following a leave of absence and is lodged in the hospital at midnight is treated as an inpatient day.

Item 19: Total Days--The total days of covered inpatient care should be shown. Any days for which payment may not be made because benefits were exhausted should be excluded. In counting days, the date of admission is counted but not the date of discharge. Where the patient was admitted and discharged on the same day (See § 3101) the total days should be shown as "1."

Item 20: Date Guarantee of Payment or UR Notice Received--This item is used to report either of the following:

A. The date that the hospital received notice that the number of inpatient days remaining was less than the number of inpatient days already provided in the current hospitalization. This date should be checked against the intermediary's record of the date on which the notice was transmitted to the hospital. (See § 3405ff and § 3608 for the evaluation of information required in these cases.) The guarantee does not apply unless the hospital establishes that it acted in good faith in assuming that the patient was entitled to have payment made for hospital services, and acted reasonably in assuming that the patient's inpatient days had not been or were not about to be exhausted.

B. The date of receipt by the hospital of the finding by the physician members of the Utilization Review Committee (or the group responsible for review of utilization) that a further hospital stay was not medically necessary should be shown. (See § 3421 for effect on payment.)

The heading which does not apply should be crossed out.

Item 21: Date Benefits Exhausted--If the patient was still hospitalized when there were no more inpatient days available, the last day for which benefits were payable should be shown. However, no entry should be shown if the reply to the Notice of Admission showed no days remaining.

Items      Discharge Information--If the patient was still hospitalized when the billing was submitted, either because  
22 - 23:      this is not a final billing or the patient's benefit days are exhausted, "Still Patient" should be checked. Otherwise, "Discharged" or "Died" should be checked in item 22. The date of discharge or death should be shown in item 23. Items 21, 22, and 23 should be reviewed in conjunction with item 18.

Item 24: Computation of Interim Payment--The computation of interim payment will not be shown by the hospital in this item on forms submitted to the intermediary. The intermediary may show the computation of the interim payment in this item. However, the reimbursement amount must always be shown. The interim rate to be applied may be a per diem rate, or percentage of charges. The method is to be arranged



between the hospital and the intermediary in accordance with reimbursement principles established by the Social Security Administration. Whatever method used, the total deductions in item 17-S should be subtracted from the total estimated costs arrived at by the interim rate agreed upon and the remainder shown as the reimbursement amount.

- Item 25: Verified Prior Stay Dates and Provider Number--This item should be completed by the intermediary upon resolution of a prior stay issue. Show the provider number of the prior-stay institution, if such institution has one (see § 3520ff). If a prior stay which would prolong a spell of illness is not established, check the "none" block.
- Item 26: Hospital Certification and Signature Lines--A hospital representative's signature should appear in this item. If no signature is shown, the hospital should be requested to submit such certification prior to payment. (See § 3601 for discussion of authorized provider signatures and listings.)
- Item 27: Approved By and Date--The intermediary's representative or official designated to approve billing payment will sign and date the form.

INPATIENT PSYCHIATRIC OR TUBERCULOSIS HOSPITAL ADMISSION AND BILLING  
HOSPITAL INSURANCE BENEFITS - SOCIAL SECURITY ACTForm Approved.  
Budget Bureau  
No. 72-R732

1. PATIENT'S LAST NAME			FIRST NAME		MI	2. HEALTH INSURANCE CLAIM NUMBER		
3. PATIENT'S ADDRESS (Street number, City, State, Zip Code)						4. DATE OF BIRTH		5. SEX <input type="checkbox"/> M <input type="checkbox"/> F
6. HOSPITAL NAME AND ADDRESS				7. PROVIDER NO.		9. NAME AND ADDRESS OF ATTENDING PHYSICIAN		
				8. MEDICAL RECORD NO.				
10. ADMITTED TO ACTIVE CARE			11. NAME AND ADDRESS OF ANY INSTITUTION (including this institution) IN WHICH PATIENT RECEIVED IN-PATIENT CARE DURING LAST 60 DAYS (If this hospital, give dates of stay)					
12. NAME AND ADDRESS OF ANY PSYCHIATRIC OR TUBERCULOSIS INSTITUTION WHICH FURNISHED INPATIENT SERVICES AT ANY TIME DURING 90 DAY PERIOD PRECEDING EFFECTIVE DATE FOR HOSPITAL INSURANCE (If this hospital, give dates of stay)								
13. PAYMENT SOURCE FOR CHARGES TO PATIENT <input type="checkbox"/> SELF OR FAMILY <input type="checkbox"/> BLUE CROSS BLUE SHIELD <input type="checkbox"/> PUBLIC AGENCY (Give name) <input type="checkbox"/> PRIVATE INSURANCE <input type="checkbox"/> EMPLOYER OR UNION <input type="checkbox"/> OTHER (Explain)								
14. PATIENT'S CERTIFICATION: AUTHORIZATION TO RELEASE INFORMATION AND PAYMENT REQUEST. I certify that the information given by me in applying for payment under Title XVIII of the Social Security Act is correct. I authorize release of all records required to act on this request. I request that payment of authorized benefits be made on my behalf.								
SIGNATURE (Patient or authorized representative) (Signature by mark must be witnessed)								DATE
15. ADMITTING OR CURRENT DIAGNOSIS    EMPLOYMENT RELATED <input type="checkbox"/> YES <input type="checkbox"/> NO (If yes, give name and address of employer.)								
16. DISCHARGE DIAGNOSES OR CURRENT DIAGNOSES (Primary illness and secondary or complicating illnesses)								Do Not Use This Space
17. SURGICAL PROCEDURES (Related to primary illness and other—Show date of each)								

STATEMENT OF SERVICES RENDERED				TOTAL CHARGES	NON-COVERED CHARGES	19. STATEMENT COVERS PERIOD FROM TO		20. TOTAL DAYS
ACCOMMODATION	DAYS	RATE						
A. 1-Bed				\$	\$			
B. 2-3-4 Bed								
C. 5 or more Beds								
D. Intensive Care								
E. Self Care								
F. WHOLE BLOOD	PINTS FURNISHED	NOT REPLACED	CHARGE PER PINT					
G. Operating Room								
H. Pharmacy								
I. Laboratory								
J. Radiology								
K. Medical, Surgical and Central Supplies								
L. Anesthesia								
M. Inhalation Therapy								
N. Other (Describe)								
O. TOTALS				\$	\$			
P. Inpatient Deductible								
Q. Blood Deductible                      Pts. @								
R. Coinsurance								
S. TOTAL DEDUCTIONS								
I certify that the required physician's certification and recertifications are on file.								
28. SIGNATURE OF HOSPITAL REPRESENTATIVE					DATE FORWARDED		29. APPROVED BY	
							DATE	

27. VERIFIED PRIOR STAY DATES			PROVIDER NO.
<input type="checkbox"/> NONE	FROM	TO	
DAYS USED			
Reimbursement Amount \$			
FOR INTERMEDIARY USE			

3630. REVIEW OF INPATIENT PSYCHIATRIC OR TUBERCULOSIS HOSPITAL  
ADMISSION AND BILLING (FORM SSA-1485)

Items 1-15 provide the necessary identification, and admission data as well as information which will alert intermediaries to possible noncovered stays or workmen's compensation involvement. Items 16-29 provide diagnoses, surgical procedures, service and billing data. The intermediary should carefully review the billing form with respect to both the admission data and the billing entries. The following discusses how the hospital is to complete the various items on this form which must be reviewed by the intermediary.

Item 1: Patient's Identification.--The patient's name will be shown with the last name first, but otherwise should be the same as that shown on his health insurance card.

Item 2: Health Insurance Claim Number.--The health insurance claim number should be checked at the time the admission data is received. (See §3504.) The health insurance number should also be checked against the Social Security Administration reply to the notice of admission and corrections made as appropriate.

Item 3: Patient's Address.--The patient's mailing address should be shown in this item. The intermediary will not normally be required to review this item.

Items 4 and 5: Date of Birth and Sex.--The date of birth should be shown in item 4. However, the date of birth may not be shown if it is not available after the provider has made a reasonable effort to obtain it (see §3507.8). Six-digit numbers are used for the date of birth, e.g., 01/02/95 for January 2, 1895. This information is provided to assist in identifying the patient, and the sex designation should be reviewed in conjunction with items 15, 16, 17, diagnoses and surgical procedures to identify inconsistencies.

Items 6, 7 and 8: Hospital and Medical Record Identification.--The name and address of the hospital and the hospital's health insurance provider number should be entered. These items may have been preprinted on all copies of the hospital's supply of these forms. The intermediary should check the accuracy of these items.

The patient's medical record in item 8 may be shown by the hospital if the hospital assigns one and it is needed by the hospital for association and reference purposes. The intermediary need not review this item.



- Item 9: Attending Physician.--The name and address of the attending physician should be shown. The name should be that of the physician who would normally be expected to certify and recertify the medical necessity of the hospital stay. If this item is omitted, it need not be obtained unless this information is needed to properly route the "Carrier Copy" of the form. (See §3605.)
- Item 10: Admitted to Active Care.--This is the date (to be shown in six-digit numbers, e.g., 07/15/66) the patient was admitted for active treatment or a medically necessary inpatient diagnostic study. This will ordinarily be the day on which the patient is admitted to the hospital or distinct part of a hospital which is equipped for the treatment or diagnostic services, even where the actual treatment or diagnostic procedures did not begin until a later date.
- Item 11: Prior Stay Information.--The name and address of any hospital or extended care facility from which the patient was discharged as an inpatient within the last 60 days before the present admission. If the prior stay was in the same hospital from which the admission notice is initiated, the dates of stay will be shown. (See §3520 for instructions on verifying the prior inpatient stay.) Where the patient was in a hospital, but not in a part of the hospital which has been certified as meeting the definition of a psychiatric or tuberculosis hospital, "this hospital--stay before admission to active treatment from (date) to (date)" should be shown.
- Item 12: Name and Address of Any Psychiatric or Tuberculosis Institution Which Furnished Inpatient Services At Any Time During the 90-Day Period Preceding Hospital Insurance Entitlement.--This is the name and address of any psychiatric or tuberculosis institution which furnished inpatient services in the 90-day period preceding the patient's first entitlement to hospital insurance. The effective date of the patient's entitlement to hospital insurance is shown on the reply to the notice of admission. If inpatient services were furnished in the prior 90-day period by the institution which has submitted the bill, the following will be shown:
- (a) If it is a stay in a hospital or part of a hospital which meets the definition of a psychiatric or tuberculosis hospital, "this hospital--from (date) to (date)" will be shown.

- (b) If the stay was in that part of the hospital which does not meet the definition of a psychiatric or tuberculosis hospital, "this hospital--not for active treatment--from (date) to (date)" will be shown. (See §3520 for verification of prior stays.)

If the individual is an inpatient of a psychiatric or tuberculosis hospital on the first day of the first month of his entitlement to hospital insurance, the days on which he was an inpatient of such a hospital in the 90-day period immediately before his first day of entitlement must be subtracted from the 90 days of inpatient services for which he would otherwise be eligible in his first spell of illness. However, the days an individual spends in an institution which does not qualify as a psychiatric or tuberculosis hospital (or in a non-qualifying part of an institution which does qualify) in the 90-day period before entitlement, should not be deducted from the 90 days of inpatient psychiatric or tuberculosis hospital services to which the individual would be entitled during his first spell of illness. On the other hand, if an individual was in a non-qualifying general hospital on the first day of his entitlement and was later transferred to a qualified general hospital, he would be entitled to have 90 days of inpatient hospital services during that spell of illness.

Item 13: Payment Source.--The hospital will show all sources that will pay amounts of the bill which cannot be paid for by the health insurance program. If a State public welfare agency will pay or has paid for such amounts, the name and address of the agency will be entered.

Item 14: Patient's Certification and Payment Request.--This item should have the patient's signature, or the signature of someone filing on behalf of the patient. Where someone files on behalf of the patient, an accompanying statement should be attached explaining the relationship of the signatory to the patient and the circumstances that made it impracticable for the patient to sign. (See §3302.)

Where the patient's signature is by mark, the mark must be witnessed by someone who knows him. The witness's name and address would be shown.

If the bill submitted, however, is a subsequent bill in connection with the same hospital admission, this item need not be completed. Similarly, if the bill is submitted for purposes of satisfying §3610, Inpatient Billing After Exhaustion of Benefits, no signature need be shown.



- Item 15: Admitting or Current Diagnosis.--The admitting diagnosis as furnished by the physician to the hospital is provided for use in reviewing admission notices, where applicable, so that the intermediary may be alerted to the possibility of non-covered services. An essential part of this item is the information solicited regarding whether or not the condition was work-related. See §§3409ff for a description of the necessary consideration required in handling workmen's compensation involvement.
- Item 16: Discharge Diagnoses or Current Diagnoses.--The discharge diagnoses should reflect information contained in the patient's medical record relating to all conditions causing the current episode of hospitalization. If two or more diagnoses are shown, the one shown first should be the most significant of the conditions. The first diagnosis should show "primary" in parenthesis next to the entry. The diagnoses should be in accordance with recognized nomenclature, e.g., Current Medical Terminology, Standard Nomenclature of Diseases and Operations. If no diagnoses are shown, the information should be obtained from the hospital prior to payment and the appropriate entry made. This item should be reviewed in conjunction with item 18 and may also serve to alert the intermediary to possible noncovered services.
- Item 17: Surgical Procedures.--Surgical procedures performed during this billing period should be shown as entered in the patient's medical record. The first procedures listed should be related to the primary diagnosis. Surgical procedures should be specified in detail using recognized nomenclature such as that used in Current Medical Terminology, Standard Nomenclature of Diseases and Operations, etc. For the purposes of this item, surgery includes incision, excision, amputation, introduction, endoscopy, repair, destructions, suture and manipulations. This item should be reviewed in conjunction with item 18 and may alert the intermediary to possible noncovered services or omissions, e.g., no operating room charges are shown on the bill.
- Item 18: Statement of Services Rendered.--All charges should be shown. (See §3602 where ledger sheets are used.) Where the hospital has more departments than shown on the form, the charges should be combined, where appropriate, for purposes of completing the form. Any charge which cannot be applied to one of the items shown should be described in 18 N-Other. All charges--



covered and noncovered--should be shown in the "Total Charges" column. Charges for noncovered services and items, except for the services of hospital-based physicians, are itemized in the "Noncovered Charges" column. A statement will be attached by the hospital where it is necessary to explain an item.

The amounts paid to a provider of services under the hospital insurance plan, subject to the deductible and coinsurance provisions, should be the estimated reasonable cost of the services. The intermediary is responsible for checking the accuracy of the total charges, estimated costs, and deductions.

#### Accommodation

A. One Bed--Where a patient needed a private room for medical reasons one copy of the SSA-1484, Explanation of Accommodation Furnished (See §3635) should be attached to explain the medical necessity for such accommodation. The customary charge for a one-bed accommodation in the "Rate" column should be shown and the "Total Charges" column will be completed.

If the patient was in a one-bed accommodation for other than medical reasons, payment cannot be made for more than the most prevalent two-, three-, or four-bed accommodation rate. In such cases an SSA-1484 will not be required and the charge for the one-bed accommodation should be entered in the "Rate" column. The difference between the total one-bed room charges and the accommodation charges which would have been made if the patient had occupied a two-, three-, or four-bed room (at the most prevalent rate for such a room at the time of admission) should be shown in the "Noncovered Charges" column.

B. Two-, Three-, or Four-Bed--If the patient occupied semiprivate accommodations (two-, three-, or four-bed room) the number of days and the actual daily rate for the accommodations should be shown.

C. Five or More Beds--Under the hospital insurance program, payment is made for semiprivate accommodations (two-, three-, or four-bed room). If the patient is assigned to a room with five or more beds, the hospital should complete Form SSA-1484, Explanation of Accommodation Furnished, in duplicate, explaining the reasons for this accommodation, and these forms are attached to the billing form. If the patient requested the assignment, only one copy of the SSA-1484 is necessary. Where the patient requested a five or more bed assignment, or the reason for assignment is one that the intermediary can approve, the

reimbursement will be made for the reasonable costs of the actual accommodation furnished. However, where the ward accommodation was provided not at the patient's request, nor for a reason which the intermediary can approve, payment will be made, at the end-of-the year settlement, on the basis of the reasonable cost of semiprivate accommodations minus the difference between the hospital's customary charge for semiprivate accommodations and its customary charge for ward accommodations. In either case, the customary ward charge should be shown in the "Rate" column on the billing form. But when the ward accommodation was not requested by the patient or approved by the intermediary, the hospital should show its customary charge for semiprivate accommodations, at the most prevalent rate at the time the accommodation was made, on the Form SSA-1484, so that the intermediary can compute the payment due. If the hospital has only ward accommodations, the actual rate should be used for accommodations furnished. No supplemental statement is necessary. (See §3635 for a full description of the Explanation of Accommodations Furnished form.)

D and E. Intensive Care and Self-Care.--The number of days the patient was in an intensive or self-care unit, applicable rate, and total charges should be shown.

The total number of days in the various accommodations shown on the form should equal the number of days shown in item 19, Statement Covers Period. Where some of the days cannot be paid for because benefits were exhausted before discharge or death, charges for days after benefits were exhausted should be shown in "Noncovered Charges."

F. Whole Blood.--This item should reflect the pints of whole blood furnished, the number of pints not replaced, and the charge per pint of such blood. The charge per pint entry should reflect the cost of such blood excluding charges for administering the blood. The "Total Charges" column will show the combined amount of the cost for pints not replaced and the charges for administering the blood.

G-N. General.--Item G includes recovery room and item H includes intravenous solution.

Where items and services are furnished which are more expensive or in excess of the services covered by the program, the difference between the amount customarily charged for such services requested and the amount customarily charged for covered services should be shown as noncovered charges. An example of this would be luxury meals at extra cost.



O. Totals.--The total charges and the total noncovered charges should be shown.

P. Inpatient Deductible.--The amount of the deductible which is applicable is shown on the reply to the notice of admission. The amount to be shown in this item (in the "Noncovered" column) is \$40 unless the deductible has been met in full or in part. Where the full deductible has not been met, the remaining deductible to be met should be shown. The only exception to this is where the total charges shown in O minus any physicians' services included in that total charge, is less than the remaining deductible to be met. Where this is the case, the difference between the total charges and the physicians' services should be shown in this item:

Example: The beneficiary has met no part of the deductible. However, the total charges (Item O) is \$42 and the charges for physicians' services included in the \$42 is \$5.00. Therefore, \$37.00 should be shown in P.

Q. Blood Deductible.--Where whole blood has been furnished to the patient (Item F) and a remaining blood deductible is shown on the reply to the notice of admission, the number of pints of the deductible remaining should be shown in this item as well as the cost of the blood per pint (excluding the cost for administering the blood). The cost of the blood per pint should be multiplied by the number of pints and the sum shown in the "Noncovered Charges" column.

R. Coinsurance.--The coinsurance days are the 61st day through the 90th day. The number of coinsurance days should be multiplied by \$10 and the sum shown in the "Noncovered Charges" column. If a patient was receiving care in a qualified psychiatric or tuberculosis hospital, or distinct part of a psychiatric or tuberculosis hospital, in the 90 days before his entitlement to hospital insurance, these days may count against the 90 days available in a spell of illness. However, they do not count toward the 190-day limit on inpatient psychiatric hospital services. Also, for the purpose of figuring when coinsurance first applies, the inpatient psychiatric or tuberculosis hospital days before entitlement are not counted. (See § 3203 for a discussion and example of this provision.)

S. Total Deductions.--The total of any amount appearing in items P through R.



Item 19: Statement Covers Period.--The beginning and ending days of the period covered by the bill should be shown. The beginning date should be no earlier than the first day of the beneficiary's date of entitlement even though the date of admission in item 10 may be before that date. Where the patient was admitted before July 1, 1966, show 07/01/66 in the "From" item. In the "To" item, show the date of death or discharge.

Where the patient was still in the hospital, the last day of the period being reported on the bill will be shown, whether or not this last day was a day of covered services.

(See §3610 for completion of forms where benefit days are exhausted.)

Where inpatients of a hospital leave the hospital for planned leaves of absence or where they are absent without leave, the following rules apply in determining which days are to be counted as inpatient days.

1. Patient Does Not Return to Hospital by Midnight of the Same Day.--Where an inpatient leaves a hospital on a given day and does not return by midnight of the same day, such day is treated as a day of discharge.

2. Patient Returns to Institution.--The day on which a patient returns to the hospital following a leave of absence and is lodged in the hospital at midnight is treated as an inpatient day.

Item 20: Total Days.--The total days of covered inpatient care should be shown. Any days for which payment may not be made because benefits were exhausted should be excluded. In counting days, the date of admission is counted but not the date of discharge. Where the patient was admitted and discharged on the same day (see §3101) the total days should be shown as "1."

Item 21: Date Active Care Ended.--The date on which active treatment ended should be shown. If this is an interim billing and the patient is still receiving active treatment, "Continuing" should be checked.

Item 22: Date Guarantee of Payment or UR Notice Received.--This item is used to report either of the following:

- A. The date that the hospital received notice that the number of inpatient days remaining was less than the number of inpatient days already provided in the current hospitalization. This date should be checked against the intermediary's record of the date on which the notice was transmitted to the hospital. (See § 3405ff and 3608 for the evaluation of information required in these cases.) The guarantee does not apply unless the hospital establishes that it acted in good faith in assuming that the patient was entitled to have payment made for hospital services, and acted reasonably in assuming that the patient's inpatient days had not been or were not about to be exhausted.
- B. The date of receipt by the hospital of the finding by the physician members of the Utilization Review Committee (or the group responsible for review of utilization) that a further hospital stay was not medically necessary should be shown. (See § 3421 for effect on payment.)

The heading which does not apply should be crossed out.

Item 23: Date Benefits Exhausted.--If the patient was still hospitalized when there were no more inpatient days available, the last day for which benefits were payable should be shown. However, no entry should be shown if the reply to the notice of admission showed no days remaining.

Item 24 and 25: Discharge Information.--If the patient was still hospitalized when the billing was submitted, either because this is not a final billing or the patient's benefit days are exhausted "Still Patient" should be checked. Otherwise, "Discharged" or "Died" should be checked in item 24. The date of discharge or death should be shown in item 25. Items 23, 24, and 25 should be reviewed in conjunction with item 19.

Item 26: Computation of Interim Payment.--The computation of interim payment will not be shown by the hospital in this item on forms submitted to the intermediary. The intermediary may show the computation of the interim payment in this item. However, the reimbursement amount must always be shown. The interim rate to be applied may be a per diem rate, or percentage of charges. The method is to be arranged between the hospital and the intermediary in accordance with reimbursement principles established by the Social Security Administration. Whatever method used, the total deductions in item 17-S should be subtracted from the total estimated costs arrived at by the interim rate agreed upon

and the remainder shown as the reimbursement amount.

Item 27: Verified Prior Stay Dates and Provider Number.-- This item should be completed by the intermediary upon resolution of a prior stay issue. Show the provider number of the prior stay institution of such institution has one. (See § 3520 ff.) If a prior stay which would prolong a spell of illness was not established, the "none" block should be checked.

The days on which the patient was an inpatient of a psychiatric or tuberculosis hospital in the 90-day period immediately before the first day of entitlement, must be subtracted from the 90 days of inpatient hospital services for which he would be otherwise eligible in his first spell of illness. Both admission and discharge days in the pre-entitlement period count as inpatient days.

The "Days Used" item should show the number of days to be charged toward the 90 day inpatient services in the first spell of illness.

Item 28: Hospital Certification and Signature Lines.--A hospital representative's signature should appear in this item. If no signature is shown, the hospital should be requested to submit such certification prior to payment. (See § 3601 discussion of authorized provider signatures and listings)

Item 29: Approved By and Date.--The intermediary's representative or official designated to approve billing payment will sign and date the form.







# EXPLANATION OF ACCOMMODATION FURNISHED

1. PATIENT'S LAST NAME	2. HEALTH INSURANCE CLAIM NUMBER
3. HOSPITAL OR EXTENDED CARE FACILITY NAME AND ADDRESS	4. PROVIDER NO.
	5. MEDICAL RECORD NO.

## TYPE OF ACCOMMODATION FURNISHED

6A. MOST PREVALENT SEMI-PRIVATE RATE			\$		
B. 1-BED			C. 5-OR-MORE-BED		
FROM (Date)	TO (Date)	RATE	FROM (Date)	TO (Date)	RATE

## REASON FOR ASSIGNMENT TO ACCOMMODATION MENTIONED

7A. PATIENT'S REQUEST — The 5-or-more-bed accommodation shown above was furnished because I requested it.

PATIENT'S SIGNATURE	DATE
---------------------	------

B. MEDICAL NECESSITY (Describe)

C. OTHER REASON (Specify)

D. SIGNATURE OF HOSPITAL REPRESENTATIVE	8. DATE
---	---------

## FOR INTERMEDIARY USE

9. Where intermediary determines that assignment to 5-or-more-bed room was not at patient's request, or was not consistent with the purposes of the Act, give difference between total of charges for accommodation at the most prevalent 2-3-4 bed room rate and charges for a 5-or-more-bed room for all covered days included on bill for services attached.	\$
10. INTERMEDIARY APPROVAL	DATE

3635. REVIEW OF THE EXPLANATION OF ACCOMMODATION FURNISHED (SSA-11484)  
--Form SSA-11484, Explanation of Accommodation Furnished, should be completed by the hospital to explain an accommodation furnished other than a two-three-or-four bed room. It should be attached to the hospital's regular billing form.

The cost of a one-bed accommodation is covered by hospital insurance if it is medically necessary. If thus required, the reason should be explained on the SSA-11484. However, when a beneficiary requests a one-bed accommodation for reasons of personal preference, he must pay the difference between the semiprivate rate and the one-bed rate. If this occurs, the hospital should show the one-bed rate in the total charges column in item 17A of the SSA-11453 and item 18A of the SSA-11485, and the difference between the one-bed charges and the most prevalent semiprivate charges in the noncovered charges column. It is not necessary in this situation to complete form SSA-11484 or attach any special explanation to the hospital billing form.

Where the assignment of a five-bed accommodation was neither at the request of the patient nor for a reason which could be approved, the hospital will be subject to the special deduction in its cost settlement.

The reason for the assignment of a five-bed accommodation should be given on the SSA-11484. If the patient requested this accommodation, he should sign the SSA-11484.

The hospital need not complete this form on individual claims if SSA has given its general approval for reimbursement for one-bed accommodations which are not medically necessary, for example, all rooms are private rooms; or for unrequested assignments to a five-or-more bed room where only ward accommodations are available.

Where a patient was furnished a private room for medical reasons, a single copy of the SSA-11484 should be completed. If the patient was assigned to a room with five-or-more beds, the SSA-11484 must be completed in duplicate.

#### Review of the Explanation of Accommodation Furnished Form

Items 1-5 of this form contain identification information and should contain the same entries as the provider bill to which it relates.

Item 6: Type of Accommodation Furnished.---This section calls for the period for which the accommodation was furnished and the applicable daily rate for the accommodation furnished. Item 4, the most prevalent semiprivate rate, should be



completed in all cases. This will be the semiprivate rate most frequently used in the hospital. The dates entered in items B and C should agree with the information in item 17 on the Inpatient Hospital Billing SSA-1153 and item 18 on the Inpatient Psychiatric and Tuberculosis Hospital Billing.

Item 7: Reason for Assignment to Accommodation Mentioned

A. Patient's Request--Where a five-or-more bed accommodation was furnished at the patient's request, the patient should have signed the SSA-1184 in this block.

B. Medical Necessity--The reason for the assignment of a patient to a one-bed room as shown by the physician's order for such accommodation should have been entered here.

C. Where the hospital believes that an assignment to a one-bed or 5-or-more-bed room accommodation is justifiable for some other reason, the reason must be described in this block.

D. Signature of Hospital Representative--The signature of the hospital's representative and the date the form was signed should appear here.

Item 8: This item should have the date the signature in 7D is affixed.

Item 9: For Intermediary Use--to make any necessary computations.

Item 10: Intermediary Approval--The intermediary representative will sign his name and show the date of approval. This signature will be shown whether or not the determination made is that the 5-or-more-bed room was not consistent with the purposes of the Act or requested by the patient.

Where a determination is made that the accommodation was not consistent with the purposes of the Act and was not requested by the patient, a copy of the form should be sent to SSA. (See § 3309 for transmitting the form to SSA.)

**3640. OUTPATIENT HOSPITAL BILLING (FORM SSA-1483)**

The Part A intermediary will receive this billing form when the hospital is claiming reimbursement for outpatient services. See the sections below and §§ 3110 - 3115.6 for covered services.

**3640.1 Outpatient Hospital Services.**--The services furnished by hospitals to outpatients are of two types:

1. diagnostic services
2. services that aid the physician in the treatment of his patient

Generally, the diagnostic services are covered under the hospital insurance program, and all other hospital services provided on an outpatient basis are covered under the medical insurance program.

**A. Diagnostic Services.**--These services include the various examinations and tests which the physician uses in developing a diagnosis of the patient's medical conditions or in evaluating changes during the course of treatment. Among these examinations and tests are diagnostic laboratory services such as hematology and chemistry, diagnostic X-rays, isotope studies, EKG's, pulmonary function studies, thyroid function tests, and psychological tests.

When furnished by the hospital, diagnostic services, including the services of nurses and technicians, and the use of supplies and equipment are covered under the hospital insurance program. Where the hospital makes arrangements with other qualified facilities for diagnostic services, such services are covered under the hospital insurance program only if they are provided (a) in the hospital (e.g., through lease agreement) under arrangements which provide for the billing to be made through the hospital, or (b) by another facility (with similar arrangements for billing) operated by or under the supervision of the hospital or its medical staff. Where the hospital bills for diagnostic services provided by qualified facilities which do not meet the above requirements, payment can be made to the hospital under the medical insurance program.

**B. Other Services Which Aid the Physician in the Treatment of His Patient.**--The medical insurance program covers these services. Most clinic visits as well as services provided in emergency cases are in this category. Special items and services which would be covered when furnished during a visit to the clinic include, for example, the services of nurses and technicians, use of emergency room, medical supplies such as gauze, dressings,

ointments, splints, braces, and other supplies used by the physician in treating the patient, drugs and biologicals which cannot be self-administered, radiology treatments, and special therapy treatments.

3640.2 General Rule for Separating Hospital Outpatient Services on Billing Forms.--Outpatient hospital services covered under the two programs must be separately identified on the Outpatient Hospital Billing form. However, since a patient may receive services covered under both programs during a single visit to the outpatient department, questions will come up about how to classify a particular service. If the physician designates the services as being for diagnostic purposes, and separates them from services that are not diagnostic, the hospital will bill accordingly. Normally, however, the physician does not separate the services and need not be asked to do so. Where such a separation of services is not made, hospital personnel preparing the bill and fiscal intermediary personnel authorizing payment should use the following rules in deciding how to allocate costs to the hospital and the medical insurance programs.

A. Any diagnostic laboratory test or other identifiable diagnostic test furnished by the hospital (or under arrangements as described in Diagnostic Services above) and normally identified as such for billing purposes, should be billed to the hospital insurance program. Any service which can be billed to hospital insurance under this rule must be billed to that program.

B. All other clinic services and emergency services (even though they may contain some diagnostic implications but are not normally identified as diagnostic services) will be billed to the medical insurance program.

3640.3 Payments Under the Hospital Insurance Plan and the Medical Insurance Plan.--Under the hospital insurance plan, benefits are paid on the basis of a period called a "diagnostic study." A diagnostic study is a 20-day period during which the same hospital provides diagnostic services for a patient. For each such 20-day period, the patient is responsible for paying the first \$20 (the deductible) and for 20 percent (coinsurance) of the remaining hospital charges. If a series of diagnostic tests lasts longer than 20 days, the \$20 deductible must be imposed at the beginning of each succeeding 20-day period during which outpatient diagnostic services are provided. Each \$20 deductible counts as an expense incurred by the patient under the medical insurance plan.



Under the medical insurance plan, the patient is responsible for the first \$50 (the deductible) of covered services received in each calendar year. After this deductible is met, the patient pays 20 percent (coinsurance) of the reasonable charges for covered services. As indicated above, any \$20 deductible imposed under the hospital insurance program counts as an incurred expense for medical insurance and may therefore be used to help satisfy the medical insurance deductible.

3640.4 Services Provided by Physicians, Interns, and Residents.--

The professional services of a physician in connection with the care of a beneficiary are not payable under the hospital insurance program. These services must be billed separately to the medical insurance program and will be reimbursed on a reasonable charge basis.

However, a hospital may, upon the request of a hospital-based physician, do the billing and receive payment on behalf of the physician for his professional services rendered to outpatients. There is a special billing form (SSA-1554), see § 3607 above, for the hospital to use in billing for the physician's professional services rendered to patients.

3640.5 Processing Outpatient Diagnostic Bills.--SSA does not keep a central control on the status of the \$20 diagnostic deductible. While hospitals may usually be expected to complete a study before submitting a bill, a patient may have additional diagnostic charges for a study period for which a bill has already been submitted. The intermediary should establish any necessary controls to assure that the deductible is not used more than once for the same 20-day study period.

When hospital costs are greater than charges, the intermediary must be especially careful to relate all outpatient bills for the same study period before determining payment. See examples 1A & 1B.

The 20-day study period, of course, applies only to Part A diagnostic, and not to medical insurance bills.

3640.6 Query of the Social Security Administration Central

Record.--When the intermediary receives an outpatient billing, it will query the SSA control records for the Part B deductible status information required to compute the payments in accordance with sections 3512.6 and 3525-3529.

In addition to securing this information regarding the individual's \$50 deductible status, the intermediary should check its records to determine whether there is another outpatient billing form from the same hospital during the same 20-day diagnostic period, to assure the outpatient hospital diagnostic deductible is charged only once.

3640.7 Completion of Items on the Form by the Hospital.--The items on the outpatient form will be completed as follows:

OUTPATIENT HOSPITAL BILLING  
HOSPITAL AND MEDICAL INSURANCE BENEFITS - SOCIAL SECURITY ACTForm Approved.  
Budget Bureau No. 72-R738

1. PATIENT'S LAST NAME		FIRST NAME	MI	2. HEALTH INSURANCE CLAIM NUMBER	
3. PATIENT'S ADDRESS (Street number, City, State, Zip Code)				4. DATE OF BIRTH	5. SEX <input type="checkbox"/> M <input type="checkbox"/> F
6. HOSPITAL NAME AND ADDRESS		7. PROVIDER NO.		9. NAME AND ADDRESS OF PHYSICIAN REQUESTING OUTPATIENT SERVICES	
		8. MEDICAL RECORD NO.			
10. PAYMENT SOURCE FOR CHARGES TO PATIENT <input type="checkbox"/> SELF OR FAMILY <input type="checkbox"/> BLUE CROSS BLUE SHIELD <input type="checkbox"/> PUBLIC AGENCY (Give name) <input type="checkbox"/> PRIVATE INSURANCE <input type="checkbox"/> EMPLOYER OR UNION <input type="checkbox"/> OTHER (Explain)					11. DATE OF FIRST VISIT

12. PATIENT'S CERTIFICATION: AUTHORIZATION TO RELEASE INFORMATION AND PAYMENT REQUEST. I certify that the information given by me in applying for payment under Title XVIII of the Social Security Act is correct. I authorize release of all records required to act on this request. I request that payment of authorized benefits be made on my behalf.

SIGNATURE (Patient or authorized representative) (Signature by mark must be witnessed)

DATE

13. DIAGNOSES (Primary illness and secondary or complicating illnesses) EMPLOYMENT RELATED ☐ YES ☐ NO If yes, give name and address of employer.

Leave Blank

14. DATE OF EACH SERVICE	FULLY DESCRIBE SURGICAL OR MEDICAL PROCEDURES AND OTHER SERVICES OR SUPPLIES FURNISHED FOR EACH DATE GIVEN	TOTAL CHARGES	HOSPITAL PLAN CHARGES	MEDICAL PLAN CHARGES	NON-COVERED CHARGES		
15A. Total Occasions of Service	HOSPITAL PLAN	MEDICAL PLAN	15B. Total Charges	\$	\$	\$	\$
16. Professional component included in 15B total charges							FOR INTERMEDIARY USE
17. 15B total charges less professional component shown in 16							VERIFIED PATIENT LIABILITY
18. PATIENT PAID		A. Deductible					
		B. Coinsurance					
FOR INTERMEDIARY USE						PAYMENT DISTRIBUTION	
19. PART A	A. REIMB. RATE	B. A TIMES 15	C. DEDUCTIBLE	D. B LESS C	E. 80% OF D	HOSPITAL	PATIENT
20. PART B							
21. PART A DEDUCTIBLE AS PART B EXPENSE	A. DEDUCTIBLE AMOUNT	B. REMAINING PART B DEDUCTIBLE	C. A LESS B	D. 80% OF C			
TOTALS						\$	\$

I certify that the required physician's certification is on file.

22. SIGNATURE OF HOSPITAL REPRESENTATIVE	DATE FORWARDED	23. APPROVED BY	DATE



A. Items 1-10 and 12 contain basic identification and certification data and will be completed in the same manner as items 1-9, 12, and 13 of the Inpatient Hospital Admission and Billing form (SSA-1453).

B. Item 11: Date of First Visit.--This date should be the first date in which the patient was seen for the purpose of a 20-day diagnostic study. It will be used to measure the allowable period for a given diagnostic study which may not exceed 20 consecutive days. This date should not be later than the first date shown for hospital plan charges.

C. Item 13: Diagnoses.--From the patient's hospital record, the diagnoses of the conditions for which outpatient services were given will be listed here. If diagnosis is not known, "Not Known" will be entered. The appropriate block to show whether the condition was employment related will be checked and the name and address of the employer, if known, will be shown. (Hospital and/or medical insurance benefits cannot be paid for services if workmen's compensation payments were made for the same services. Payment may be made under hospital and/or medical insurance subject to reimbursement if the workmen's compensation case is pending and no settlement is foreseeable. (See section 3407.)

D. Item 14: Statement of Services.--For each date given, the names of all medical procedures--laboratory tests, radium therapy, etc.--performed during the period covered by this billing are listed. The name of any operation or endoscopic procedure performed during the billing period is also listed, as well as any supplies or equipment furnished.

Medical and surgical procedures other than laboratory tests should be specified in detail using acceptable terminology such as that indicated by the Current Medical Terminology, Current Procedural Terminology, Standard Nomenclature of Diseases and Operations, the American Psychiatric Association's Diagnostic and Statistical Manual, etc.

The hospital should, to the extent possible, report laboratory tests by date of each service or inclusive dates of service using the following descriptive categories:

- |                        |                       |
|------------------------|-----------------------|
| 1. Hematology          | 7. Feces Examinations |
| 2. Blood Chemistry     | 8. Gastric Analysis   |
| 3. Virology            | 9. Spinal Fluid Exams |
| 4. Serology            | 10. Sputum Exams      |
| 5. Urinalyses          | 11. Tissue Studies    |
| 6. Clinical Microscopy |                       |



For example, a series of blood tests such as a CBC, a hematocrit, and a sedimentation rate for an individual patient would all be reported collectively as "Hematology." Other tests such as EKG, Radioisotopes Audiometric Testing, and Pulmonary Function Studies would need to be specified as would tests not falling into the categories listed. It is anticipated that very few tests will not be covered by the various descriptive categories.

For x-ray procedures, hospitals should specify the body part involved. It will not be necessary to indicate the number of examinations or the number of plates taken.

In the event the hospital is unable under its present system for outpatient billing to identify services by the descriptive categories, it may submit bills using currently available identification until January 1, 1967.

Where the hospital normally includes a charge for physicians' services in its total charge for a service, the total charges will be billed as usual, and the physician's component will not be broken out in noncovered charges. The intermediary will make a deduction for any physicians' charges in arriving at the cost reimbursement. (The physicians' services will be billed for either on the Form SSA-1490, Request for Payment, or on the Form SSA-1554, and will be reimbursed on a reasonable charge basis. Where the optional method of reimbursement for radiologists and pathologists is followed, it will not be necessary for hospitals to report the name of each laboratory and x-ray procedure on Form SSA-1554. It will be sufficient to identify the services provided on a departmental basis, i.e., laboratory, radiology, etc.)

Where the item-by-item method of determining the physician component is followed, a detailed reporting of laboratory and x-ray procedures is required. Accordingly, under this method of determining the physician component a breakout of services is required for all items for which a specific charge by the physician is being billed by the hospital.)

When a posting date for a hospital plan charge occurs more than 20 days after the date shown in item 11, the intermediary will not assume that the service is within the same 20-day study period unless the hospital also shows the exact date of that service in the "Description of Services" section.

E. Item 15: Summary of Charges

1. If the hospital is reimbursed by the intermediary on a cost per occasion of service or cost per visit basis, the

total number of occasions of service or visits represented by this bill will be entered in the appropriate hospital plan and medical plan blocks.

2. The entries in the respective columns of item 14, for total hospital plan, medical plan, and noncovered charges, should be added down. This is the hospital's usual charge, and where hospital customarily includes a charge for physicians' services in its bill, this charge will also be included in items 14 and 15. This permits a comparison of medicare beneficiary charges with charges to all hospital patients.

F. Item 16: Professional Component Included in 15B.--Any physician charges included in the charges in item 14 must be entered here for each plan. These charges must be excluded from total charges before determining the deductible and coinsurance due from the patient. These amounts will normally be billed on the SSA-1554 or SSA-1490 as physicians' charges.

G. Item 17: 15B Less 16.--The professional component (physicians' charges) is to be subtracted from the total hospital and/or medical plan charges and the results entered here. This subtraction is necessary to determine the amount which may be applied to deductible and coinsurance.

H. Item 18: Patient Paid.--The amounts, if any, paid by the patient or on his behalf for the deductible and/or coinsurance under each plan should be entered here. (Do not include any amount paid by the patient for physicians' services.)

Since the hospital may not know the correct medical plan deductible, it may prefer to wait until the intermediary has verified the deductible status or it may decide to collect the deductible and coinsurance amounts. Where the hospital decides to collect these amounts, it should have followed the guidelines given in section 420.b.1. of the Hospital Manual.

3640.8 For Intermediary Use.--The balance of the form is for the use of the intermediary in computing the payments to be made to the hospital and/or the patient.

Before computing the amounts in lines 19, 20, and 21 the intermediary should check to determine if the charges under Plan A and Plan B in item 14 are customary and reasonable.

A. The verified patient liability for deductible is the lesser of:

1. The remaining deductible as reported by SSA in the query reply, or

2. The sum of the charges shown in line 17 (but not more than \$20 in hospital plan charges).

B. The verified patient liability for coinsurance is 20 percent of the difference between the total charges in line 17 (under both Hospital Plan charges and Medical Plan charges) and the verified patient liability for deductible.

NOTE: The amounts the patient may have paid the hospital for either the deductibles or the coinsurance are not considered in determining the verified patient liability.

C. Line 19 - Part A

1. 19A: Reimbursement Rate.--This is a percentage of charges or the average cost per occasion of service or visit. The reimbursement rate will have been agreed to by the hospital and the intermediary to serve as the basis for the interim payment.

2. 19B: A Times 15 or 17.--Though the form calls for use of the reimbursement rate against item 15, a reimbursement rate established on the basis of cost excluding professional component may be applied to item 17 charges. The method used is optional with the intermediary.

3. 19C: Deductible.--For each 20 day study period, enter here the total hospital plan charge (from line 17) or the amount in 19B, whichever is greater, but in no case should the amount in 19C be greater than \$20. See Examples 1A and 1B where more than one bill is submitted for a study period.

Note that the patient's deductible is always based on charge, regardless of cost.

No Part A payment may be made unless the incurred charges (or cost, if greater) exceed \$20. See example 2.

4. 19D: B Less C.-- Subtract the deductible from the amount in 19B (interim computed cost). If the result is 0 or a minus amount, leave this space and 19E blank.

5. 19E: 80% of D.--Enter the amount equal to 80 percent of 19D. This is the interim payment to be made under Part A. See paragraph 20D for cases where the deductible has not been met.



D. Line 20 - Part B

1. 20A: Reimbursement Rate.--See 19A.
2. 20B: A Times 15 or 17.--Enter here the result of applying the reimbursement rate to the medical plan charges in items 15 or 17.
3. 20C: The amount of the Part B deductible in 20C is the larger of the Medical Plan Charge in item 17 or the Medical Plan cost in item 20B, not to exceed the unmet deductible as reported by SSA. See Example 4.
4. 20D: Where the deductible in 20C is more than 20B, leave 20D blank.

E. Line 21 - Part A

1. 21A.--This is the total diagnostic charges up to a maximum of \$20, as shown in item 17.
2. 21B.--The remaining Part B deductible as shown in item 21B is the remaining deductible as reported by the SSA query reply minus any amount shown as medical charges in item 17.
3. 21C.--Any result
4. 21D.--Reimbursement for the outpatient diagnostic deductible as an incurred expense under Part B.

3640.9 Payment Distribution.--Where the patient's payments are equal to or less than the verified patient's liability, the amounts in 19E and 20E and 21D will be paid to the hospital. Where the hospital has over-collected deductible and/or coinsurance, the payment distribution block will be used to show the refund to the patient. The hospital's payment will be reduced by any amount paid the patient.

Sometimes the refund due the patient is more than the amount due the hospital. If this should be the case, the intermediary should indicate the deficit with a minus sign in the payment distribution item in the hospital column.

Since almost all overcollections will represent an incorrect assessment of the medical plan deductible, minus entries will usually appear in item 20 or 21. In unusual cases (e.g., where the diagnostic deductible is collected twice during a 20-day study period and the patient has no medical plan entitlement), it will be possible to have a minus sign in item 19.

Item 19E should always equal the sum of the hospital and patient payment distribution in 19, and items 20E and 21D should equal the sums of the Hospital and Patient Payment Distribution for item 20 and item 21. The total of hospital and patient payments should be the total payment summary under both plans. The total hospital payment will carry a minus sign if the sum of the payments to the hospital is negative.

3640.10 Examples.

EXAMPLE 1A

Costs are 150 percent of charges, but no payment can be made, because neither costs nor charges exceed the \$20 outpatient diagnostic deductible. \$15 must be shown in item 19C, because the amount in 19B is greater than the charge. No Part A payment can be made until more than \$20 in charges or costs are incurred. (See explanation of item 19C.)

- . SSA query report shows \$50 Part B deductible to be met.
- . This is the first bill in the study period.

15A. Total Occasions of Service		HOSPITAL PLAN	MEDICAL PLAN	15B. Total Charges	\$	HOSPITAL PLAN CHARGES	MEDICAL PLAN CHARGES	
						\$ 10.00	\$	\$
16. Professional component included in 15B total charges								FOR INTERMEDIARY USE
17. 15B total charges less professional component shown in 16						10.00		VERIFIED PATIENT LIABILITY
18. PATIENT PAID		A. Deductible				10.00		10.00
		B. Coinsurance						
FOR INTERMEDIARY USE								PAYMENT DISTRIBUTION
19.	A. REIMB. RATE	B. A TIMES 15	C. DEDUCTIBLE	D. B LESS C	E. 80% OF D	HOSPITAL		PATIENT
PART A	150%	15.00	15.00					
20. PART B								
21.	PART A DEDUCTIBLE AS PART B EXPENSE		A. DEDUCTIBLE AMOUNT	B. REMAINING PART B DEDUCTIBLE	C. A LESS B	D. 80% OF C		
			10.00	50.00				
						TOTALS	\$	\$

No payment can be made because the deductible is not exceeded. Note that the patient's diagnostic charge of \$10 is used as a basis for the SSA deductible query and completion of item 21.



EXAMPLE 1B

Costs are again 150 percent of charges. Costs of \$15 were incurred on first bill during this same study period. Thus, item 19C should be \$5 (\$20 minus \$15 previously incurred costs). (See explanation of item 19C.) The intermediary must refer back to the first bill to properly complete this bill.

- SSA query report shows \$40 Part B deductible remains to be met. (\$10 of deductible met in example 1A)
- This is the second bill in the study period.

				HOSPITAL PLAN CHARGES	MEDICAL PLAN CHARGES		
15A. Total Occasions of Service	HOSPITAL PLAN	MEDICAL PLAN	15B. Total Charges	\$	\$ 10.00	\$	\$
16.	Professional component included in 15B total charges						FOR INTERMEDIARY USE
17.	15B total charges less professional component shown in 16				10.00		VERIFIED PATIENT LIABILITY
18.	PATIENT PAID						
	A. Deductible				10.00		10.00
	B. Coinsurance						
FOR INTERMEDIARY USE							PAYMENT DISTRIBUTION
19.	A. REIMB. RATE	B. A TIMES 15	C. DEDUCTIBLE	D. B LESS C	E. 80% OF D	HOSPITAL	PATIENT
PART A	150%	15.00	5.00	10.00	8.00	8.00	
20.	PART B						
21.	PART A DEDUCTIBLE AS PART B EXPENSE		A. DEDUCTIBLE AMOUNT	B. REMAINING PART B DEDUCTIBLE	C. A LESS B	D. 80% OF C	
			10.00	40.00			
TOTALS						\$ 8.00	\$

Completion of item 21 is again based on charge rather than cost. Note that the verified patient deductible is shown as \$10, even though this is less than the remaining Part B deductible. See 3640.9A.

**NOTE:** Although examples 1A and 1B illustrate that the intermediary can apply the correct Part A deductible where two or more bills are submitted within the same diagnostic study period, it is, of course, preferable for the hospital to submit only one bill for each such period.

EXAMPLE 2

In the following example, please note that the amount shown in item 19C is \$20 even though the charges on line 17 are only \$15.

- . SSA query report shows \$50 deductible to be met.
- . The reimbursement rate of 150 percent is being applied to line 17.

				HOSPITAL PLAN CHARGES		MEDICAL PLAN CHARGES	
15A. Total Occasions of Service	HOSPITAL PLAN	MEDICAL PLAN	15B. Total Charges	\$20.00	\$ 20.00	\$	\$
16. Professional component included in 15B total charges					5.00	FOR INTERMEDIARY USE	
17. 15B total charges less professional component shown in 16					15.00	VERIFIED PATIENT LIABILITY	
18. PATIENT PAID		A. Deductible				15.00	
		B. Coinsurance					
FOR INTERMEDIARY USE							PAYMENT DISTRIBUTION
19.	A. REIMB. RATE	B. A TIMES 15	C. DEDUCTIBLE	D. B LESS C	E. 80% OF D	HOSPITAL	PATIENT
PART A	150%	22.50	20.00	2.50	2.00	2.00	
20. PART B							
21. PART A DEDUCTIBLE AS PART B EXPENSE		A. DEDUCTIBLE AMOUNT		B. REMAINING PART B DEDUCTIBLE	C. A LESS B	D. 80% OF C	
		15.00		50.00			
					TOTALS	\$ 2.00	\$

No Part A payment can be made unless the incurred charges (or cost, if greater) exceeds the \$20 hospital outpatient diagnostic deductible. In this case, a \$2.00 payment was made to the hospital because the interim computed cost of \$22.50 exceeds the \$20 Part A deductible.

EXAMPLE 3

In this example the Part B costs are greater than Part B charges. The Part B costs are also greater than the \$50 Part B deductible. Thus, a Part B payment can be made, even though the Part B medical plan charges amount to less than \$50.

. SSA deductible reply shows the deductible to be met as \$50.

. Reimbursement rate is 150% of charges applied against line 15.

					HOSPITAL PLAN CHARGES	MEDICAL PLAN CHARGES		
15A. Total Occasions of Service	HOSPITAL PLAN	MEDICAL PLAN	15B. Total Charges	\$	\$ 50.00	\$ 40.00	\$	
16. Professional component included in 15B total charges					10.00	15.00	FOR INTERMEDIARY USE	
17. 15B total charges less professional component shown in 16					40.00	25.00	VERIFIED PATIENT LIABILITY	
18. PATIENT PAID	A. Deductible				20.00	25.00	45.00	
	B. Coinsurance				4.00		4.00	
FOR INTERMEDIARY USE							PAYMENT DISTRIBUTION	
19.	A. REIMB. RATE	B. A TIMES 15	C. DEDUCTIBLE	D. B LESS C	E. 80% OF D	HOSPITAL	PATIENT	
PART A	150%	75.00	20.00	55.00	44.00	44.00		
20. PART B	150%	60.00	50.00	10.00	8.00	8.00		
21. PART A DEDUCTIBLE AS PART B EXPENSE		A. DEDUCTIBLE AMOUNT	B. REMAINING PART B DEDUCTIBLE	C. A LESS B	D. 80% OF C			
		20.00	25.00					
TOTALS						\$ 52.00	\$	

Note that the verified patient liability for deductible is sum of item 17 (using no more than \$20 for the hospital plan charge) because this is less than the outstanding medical plan deductible. The amount of the diagnostic deductible plus medical plan charges is used as a basis for the deductible query. The deductible in item 20C, however, is based, within the limit of the deductible to be met, on the cost figure in 20B, since this is greater than charges. The remaining Part B deductible in item 21B is based only on the SSA deductible remaining after subtracting any medical plan charges in 17.



EXAMPLE 4

In the example below a comparison of medical plan charges and the medical plan costs shows that both exceed the unmet deductible; therefore, the latter amount is used as the deductible in item 20C.

. SSA query report shows \$20 Part B deductible to be met.

. Reimbursement rate of 150% is applied to line 15.

15A. Total Occasions of Service		HOSPITAL PLAN	MEDICAL PLAN	15B. Total Charges	\$	HOSPITAL PLAN CHARGES	MEDICAL PLAN CHARGES	
					\$		\$ 50.00	\$
16. Professional component included in 15B total charges							10.00	FOR INTERMEDIARY USE
17. 15B total charges less professional component shown in 16							40.00	VERIFIED PATIENT LIABILITY
18. PATIENT PAID		A. Deductible						20.00
		B. Coinsurance						4.00
FOR INTERMEDIARY USE								PAYMENT DISTRIBUTION
19.	A. REIMB. RATE	B. A TIMES 15	C. DEDUCTIBLE	D. B LESS C	E. 80% OF D	HOSPITAL	PATIENT	
PART A								
20. PART B	150%	75.00	20.00	55.00	44.00	44.00		
21.	PART A DEDUCTIBLE AS PART B EXPENSE		A. DEDUCTIBLE AMOUNT	B. REMAINING PART B DEDUCTIBLE	C. A LESS B	D. 80% OF C		
						TOTALS	\$ 44.00	\$

EXAMPLE 5

Where the hospital has overcollected deductible and/or coinsurance amounts the payment distribution block is used by the intermediary to make a refund to the patient. In the following example the refund to the patient actually exceeds the amount due the hospital.

. SSA query report shows 0 Part B deductible to be met.

					HOSPITAL PLAN CHARGES	MEDICAL PLAN CHARGES		
15A. Total Occasions of Service	HOSPITAL PLAN	MEDICAL PLAN	15B. Total Charges	\$ 40.00	\$ 20.00	\$ 20.00	\$	
16.	Professional component included in 15B total charges				---	---	FOR INTERMEDIARY USE	
17.	15B total charges less professional component shown in 16				20.00	20.00	VERIFIED PATIENT LIABILITY	
18.	PATIENT PAID	A. Deductible			20.00	20.00	0	
		B. Coinsurance			---	---	8.00	
FOR INTERMEDIARY USE							PAYMENT DISTRIBUTION	
19.	A. REIMB. RATE	B. A TIMES 15	C. DEDUCTIBLE	D. B LESS C	E. 80% OF D	HOSPITAL	PATIENT	
PART A	90%	18.00	20.00	---	---			
20.	PART B	90%	18.00	---	18.00	14.40	-1.60	16.00
21.	PART A DEDUCTIBLE AS PART B EXPENSE		A. DEDUCTIBLE AMOUNT	B. REMAINING PART B DEDUCTIBLE	C. A LESS B	D. 80% OF C		
			20.00	---	20.00	16.00		
					TOTALS		\$ -1.60	\$ 32.00

The following examples illustrate the completion of the computation block where the amount of charges does not change but the deductible status and hospital collection from the patient do.

EXAMPLE 6A

SSA reply to deductible query shows no remaining deductible to be met.

Hospital collects incorrect amount from patient.

15A. Total Occasions of Service		HOSPITAL PLAN	MEDICAL PLAN	15B. Total Charges	\$ 40.00	HOSPITAL PLAN CHARGES	MEDICAL PLAN CHARGES	\$ 40.00	\$
16. Professional component included in 15B total charges								FOR INTERMEDIARY USE	
17. 15B total charges less professional component shown in 16							40.00	VERIFIED PATIENT LIABILITY	
18. PATIENT PAID		A. Deductible					40.00	0	
		B. Coinsurance						8.00	
FOR INTERMEDIARY USE								PAYMENT DISTRIBUTION	
19.	A. REIMB. RATE	B. A TIMES 15	C. DEDUCTIBLE	D. B LESS C	E. 80% OF D	HOSPITAL	PATIENT		
PART A									
20. PART B	80%	32.00	0	32.00	25.60	-6.40	32.00		
21.	PART A DEDUCTIBLE AS PART B EXPENSE		A. DEDUCTIBLE AMOUNT	B. REMAINING PART B DEDUCTIBLE	C. A LESS B	D. 80% OF C			
						TOTALS	\$ -6.40	\$ 32.00	



EXAMPLE 6B

Hospital did not collect any payment from beneficiary.

. SSA query reply shows no remaining deductible to be met.

				HOSPITAL PLAN CHARGES	MEDICAL PLAN CHARGES		
15A. Total Occasions of Service	HOSPITAL PLAN	MEDICAL PLAN	15B. Total Charges	\$ 40.00	\$	\$ 40.00	\$
16. Professional component included in 15B total charges						FOR INTERMEDIARY USE	
17. 15B total charges less professional component shown in 16						40.00	VERIFIED PATIENT LIABILITY
18. PATIENT PAID		A. Deductible					0
		B. Coinsurance					8.00
FOR INTERMEDIARY USE						PAYMENT DISTRIBUTION	
19. PART A	A. REIMB. RATE	B. A TIMES 15	C. DEDUCTIBLE	D. B LESS C	E. 80% OF D	HOSPITAL	PATIENT
20. PART B	80%	32.00		32.00	25.60	25.60	
21. PART A DEDUCTIBLE AS PART B EXPENSE		A. DEDUCTIBLE AMOUNT	B. REMAINING PART B DEDUCTIBLE	C. A LESS B	D. 80% OF C		
TOTALS						\$25.60	\$

EXAMPLE 6C

Hospital collected from patient before submitting bill.

. SSA query reply shows \$50 unmet deductible.

				HOSPITAL PLAN CHARGES	MEDICAL PLAN CHARGES		
15A. Total Occasions of Service	HOSPITAL PLAN	MEDICAL PLAN	15B. Total Charges	\$ 40.00	\$	\$ 40.00	\$
16. Professional component included in 15B total charges						FOR INTERMEDIARY USE	
17. 15B total charges less professional component shown in 16						40.00	VERIFIED PATIENT LIABILITY
18. PATIENT PAID				A. Deductible		40.00	40.00
				B. Coinsurance			
FOR INTERMEDIARY USE						PAYMENT DISTRIBUTION	
19.	A. REIMB. RATE	B. A TIMES 15	C. DEDUCTIBLE	D. B LESS C	E. 80% OF D	HOSPITAL	PATIENT
PART A							
20. PART B	80%	32.00	40.00				
21. PART A DEDUCTIBLE AS PART B EXPENSE		A. DEDUCTIBLE AMOUNT	B. REMAINING PART B DEDUCTIBLE	C. A LESS B	D. 80% OF C		
TOTALS						\$	\$

NOTE: The hospital will submit the billing form even though no payment is expected so that patient's deductible record and provider's record may be updated.

The following are miscellaneous examples which further illustrate how the form should be completed.

EXAMPLE 7

- . SSA query report shows 0 Part B deductible to be met.
- . Reimbursement rate of 80% is applied to line 15.
- . Hospital has correctly collected only the coinsurance from the patient.

				HOSPITAL PLAN CHARGES	MEDICAL PLAN CHARGES		
15A. Total Occasions of Service	HOSPITAL PLAN	MEDICAL PLAN	15B. Total Charges	\$200.00	\$ 100.00	\$100.00	\$
16. Professional component included in 15B total charges					20.00	20.00	FOR INTERMEDIARY USE
17. 15B total charges less professional component shown in 16					80.00	80.00	VERIFIED PATIENT LIABILITY
18. PATIENT PAID				A. Deductible	--	--	0
				B. Coinsurance	16.00	16.00	32.00
FOR INTERMEDIARY USE							PAYMENT DISTRIBUTION
19.	A. REIMB. RATE	B. A TIMES 15	C. DEDUCTIBLE	D. B LESS C	E. 80% OF D	HOSPITAL	PATIENT
PART A	80%	80.00	20.00	60.00	48.00	48.00	
20. PART B	80%	80.00	--	80.00	64.00	64.00	
21. PART A DEDUCTIBLE AS PART B EXPENSE		A. DEDUCTIBLE AMOUNT	B. REMAINING PART B DEDUCTIBLE	C. A LESS B	D. 80% OF C		
		20.00	--	20.00	16.00	16.00	
TOTALS						\$ 128.00	\$

The verified patient liability is 0 since this is the lesser of the remaining deductible as reported by SSA in the query reply, up to \$20 of Hospital Plan charges plus the Medical Plan charges in 17. The verified patient coinsurance is 20% of the sum of line 17, since there is no medical plan deductible to subtract from this.



EXAMPLE 8

- . SSA query report shows \$30 Part B deductible to be met.
- . Reimbursement rate of 70% is applied to line 17.

					HOSPITAL PLAN CHARGES	MEDICAL PLAN CHARGES	NON- COVERED CHARGES
15A. Total Occasions of Service	HOSPITAL PLAN	MEDICAL PLAN	15B. Total Charges	\$ 200.00	\$ 115.00	\$ 75.00	\$ 10.00
16. Professional component included in 15B total charges					35.00	25.00	FOR INTERMEDIARY USE
17. 15B total charges less professional component shown in 16					80.00	50.00	VERIFIED PATIENT LIABILITY
18. PATIENT PAID	A. Deductible				--	--	30.00
	B. Coinsurance				--	--	20.00
FOR INTERMEDIARY USE							PAYMENT DISTRIBUTION
19. PART A	A. REIMB. RATE	B. A TIMES 15	C. DEDUCTIBLE	D. B LESS C	E. 80% OF D	HOSPITAL	PATIENT
	70%	56.00	20.00	36.00	28.80	28.80	
20. PART B	70%	35.00	30.00	5.00	4.00	4.00	
21. PART A DEDUCTIBLE AS PART B EXPENSE		A. DEDUCTIBLE AMOUNT	B. REMAINING PART B DEDUCTIBLE	C. A LESS B	D. 80% OF C		
		20.00	--	20.00	16.00	16.00	
TOTALS						\$ 48.80	\$

Note that the noncovered charges (\$10.00) are not used by the intermediary in the computations.

The remaining deductible is less than the medical plan charges shown in line 17, and is hence the amount in item 20C. All payments are to the hospital, since the patient's payments (none) did not exceed his verified liability.

EXAMPLE 9

- . SSA query report shows \$33 Part B deductible is to be met.
- . Reimbursement rate of 60% is applied to line 17.

				HOSPITAL PLAN CHARGES	MEDICAL PLAN CHARGES		
15A. Total Occasions of Service	HOSPITAL PLAN	MEDICAL PLAN	15B. Total Charges	\$157.00	\$ 67.00	\$ 90.00	\$
16. Professional component included in 15B total charges				17.00	40.00	FOR INTERMEDIARY USE	
17. 15B total charges less professional component shown in 16				50.00	50.00	VERIFIED PATIENT LIABILITY	
18. PATIENT PAID	A. Deductible			20.00	30.00	33.00	
	B. Coinsurance			6.00	4.00	13.40	
FOR INTERMEDIARY USE						PAYMENT DISTRIBUTION	
19.	A. REIMB. RATE	B. A TIMES 15	C. DEDUCTIBLE	D. B LESS C	E. 80% OF D	HOSPITAL	PATIENT
PART A	60%	30.00	20.00	10.00	8.00	8.00	
20. PART B	60%	30.00	33.00				
21. PART A DEDUCTIBLE AS PART B EXPENSE	A. DEDUCTIBLE AMOUNT	B. REMAINING PART B DEDUCTIBLE	C. A LESS B	D. 80% OF C			
	20.00		20.00	16.00	2.40	13.60	
					TOTALS	\$ 10.40	\$ 13.60

The verified patient liability is the sum of not more than \$20 of the hospital plan charges from line 17 plus the medical plan charges, or if less, the deductible to be met. The deductible to be met is \$33 and this is entered as the verified patient deductible. The verified patient coinsurance is 20% of the sum of line 17 after deduction of the verified deductible, or \$13.40.

The deductible applied to item 20C is \$33, the amount of the unmet deductible as shown on the SSA query report.

The patient's payments exceed his verified liability by \$13.60. This amount is deducted from the hospital's payment and paid to the patient.

EXAMPLE 10

- . SSA query shows \$10 Part B deductible to be met.
- . Reimbursement rate of 75% is applied against line 17.

				HOSPITAL PLAN CHARGES	MEDICAL PLAN CHARGES			
15A. Total Occasions of Service	HOSPITAL PLAN	MEDICAL PLAN	15B. Total Charges	\$ 57.80	\$ 19.00	\$ 38.80	\$	
16.	Professional component included in 15B total charges				5.00	5.00	FOR INTERMEDIARY USE	
17.	15B total charges less professional component shown in 16				14.00	33.80	VERIFIED PATIENT LIABILITY	
18.	PATIENT PAID	A. Deductible					10.00	
		B. Coinsurance					7.56	
FOR INTERMEDIARY USE							PAYMENT DISTRIBUTION	
19.	A. REIMB. RATE	B. A TIMES 15	C. DEDUCTIBLE	D. B LESS C	E. 80% OF D		HOSPITAL	PATIENT
PART A	75%	10.50	14.00					
20.	PART B	75%	25.35	10.00	15.35	12.28	12.28	
21.	PART A DEDUCTIBLE AS PART B EXPENSE		A. DEDUCTIBLE AMOUNT	B. REMAINING PART B DEDUCTIBLE	C. A LESS B	D. 80% OF C		
			14.00	0	14.00	11.20	11.20	
					TOTALS	\$ 23.48	\$	

The verified patient liability for deductible is \$10, the outstanding medical plan deductible to be met. This is less than the sum of no more than \$20 from the hospital plan charges in line 17 and the medical plan charges. The verified patient coinsurance is \$7.56 (20% of the sum of line 17 less the verified deductible).

No payment is made in line 19 because the deductible is not exceeded.

The deductible in 20C is \$10, the outstanding medical plan deductible, since this is less than the charge shown in item 17 under medical plan.

All payments are made to the hospital because the patient's payments (none) did not exceed his verified liability.



**HOME HEALTH AGENCY REPORT AND BILLING**  
**HOSPITAL AND MEDICAL INSURANCE BENEFITS—SOCIAL SECURITY ACT**

1. PATIENT'S LAST NAME		FIRST NAME		MI	2. HEALTH INSURANCE CLAIM NUMBER				
3. PATIENT'S ADDRESS (Street number, City, State, Zip Code)					4. DATE OF BIRTH		5. SEX <input type="checkbox"/> M <input type="checkbox"/> F		
6. HOME HEALTH AGENCY NAME AND ADDRESS			7. PROVIDER NO.		9. NAME AND ADDRESS OF ATTENDING PHYSICIAN				
			8. MEDICAL RECORD NO.						
10. DATE CARE STARTED		11. NAME AND ADDRESS OF INSTITUTION, IF ANY, CARING FOR CONDITION LATER REQUIRING HOME HEALTH SERVICES				12. VERIFIED DATES OF STAY IN ITEM 11 FROM TO		13. DATE HOME HEALTH PLAN ESTABLISHED	
14. PAYMENT SOURCE FOR CHARGES TO PATIENT									
A. <input type="checkbox"/> SELF OR FAMILY C. <input type="checkbox"/> BLUE CROSS BLUE SHIELD E. <input type="checkbox"/> PUBLIC AGENCY (Give name)									
B. <input type="checkbox"/> PRIVATE INSURANCE D. <input type="checkbox"/> EMPLOYER OR UNION F. <input type="checkbox"/> OTHER (Explain)									
15. PATIENT'S CERTIFICATION: AUTHORIZATION TO RELEASE INFORMATION AND PAYMENT REQUEST: I certify that the information given by me in applying for payment under Title XVIII of the Social Security Act is correct. I authorize release of all records required to act on this request. I request that payment of authorized benefits be made in my behalf.									
SIGNATURE (Patient or authorized representative) (Signature by mark must be witnessed)							DATE		
16. DIAGNOSES				EMPLOYMENT RELATED A. <input type="checkbox"/> YES B. <input type="checkbox"/> NO (If yes, give name and address of employer.)				LEAVE BLANK	
17. STATEMENT COVERS PERIOD FROM TO		18. DATE OF FIRST VISIT		DATE OF LAST VISIT		19. PATIENT <input type="checkbox"/> DISCHARGED <input type="checkbox"/> STILL RECEIVES SERVICES <input type="checkbox"/> DIED <input type="checkbox"/> VISITS EXHAUSTED		20. DATE APPLICABLE TO ITEM 19	
21. STATEMENT OF SERVICES RENDERED		POST-HOSPITAL PLAN		MEDICAL PLAN		22. POST-HOSPITAL PLAN		23. MEDICAL PLAN	
PRIMARY PURPOSE OF VISIT		NO. VISITS CHARGES		NO. VISITS CHARGES		A. TOTAL CHARGES		A. VERIFIED DEDUCTIBLE	
A. Skilled Nursing Care									
B. Physical Therapy								B. VERIFIED COINSURANCE	
C. Speech Therapy									
D. Occupational Therapy									
E. Medical Social Services								C. TOTAL CHARGES	
F. Home Health Aide								D. REIMBURSEMENT RATE	
G. Other Visits (Specify)									
H. Total No. of Units of Service								E. C TIMES D	
I. Charge per unit of Service \$								F. E LESS A	
J. TOTALS		\$		\$				G. REIMBURSEMENT AMT. 80% OF F	
K. Other (Specify)								H. REFUND TO PATIENT	
L. TOTAL CHARGES		\$		\$				I. NET AMOUNT TO AGENCY, G LESS H	
M. AMOUNT PAID BY PATIENT				\$					
I certify that required physician's certification and recertifications are on file.									
SIGNATURE OF HOME HEALTH AGENCY REPRESENTATIVE				DATE FORWARDED		APPROVED BY		DATE APPROVED	

**3650. HOME HEALTH AGENCY REPORT AND BILLING (FORM SSA-1487)**

This form comes in two sections. The report section gives basic information needed for the Social Security Administration to determine from its beneficiary records whether health insurance benefits are payable on behalf of the patient. (See Chapter VI.)

The lower section of the form is designed as a bill for services furnished to the patient. A billing may be submitted on a regular basis before the allowable visits are exhausted. However, it will always be submitted when services are terminated, visits are exhausted, or visits are to be charged to the other plan.

If billings are submitted before the patient is discharged, items 9, 11, 12, 15, and 16 may be omitted for second and subsequent billings from the same agency, based on the same home care plan.

If visits are clearly chargeable under the medical plan; e.g., (a) benefits are exhausted under the posthospital plan, (b) the home health agency specializes in the treatment of mental diseases, or (c) the patient does not meet the prior hospital or extended care facility stay or the physician's plan was not timely established, the agency may wish to collect any applicable deductible before the billing is submitted.

If the reply to the start of care notice shows that the \$50 deductible is met, or if the patient establishes that he has met part or all of the \$50 deductible under the medical plan by furnishing an official notice, the agency may charge him 20 percent of the total charges for its services after billing him for any remaining deductible.

If the patient has no official notice of his deductible status, the agency may charge him \$50 plus 20 percent of the excess. Any patient overpayments for the deductible and coinsurance, discovered when the intermediary verifies the status of the deductible with the Social Security Administration, should be refunded by the intermediary to the patient. However, to avoid such overpayments by the patient, the intermediary should encourage the agency to wait until the bill is paid by the intermediary before collecting from the patient unless the deductible has already been met.

Item 1: Patient's Identification.--The patient's name will be shown with the last name first, but otherwise should be the same as that shown on his health insurance card.



Item 2: Health Insurance Claim Number.--The health insurance claim number should be checked at the time the start of care data is received. (See §3504.) The health insurance number should also be checked against the SSA reply to the notice of start of care and corrections made as appropriate.

Item 3: Patient's Address.--The patient's mailing address should be shown in this item. The intermediary will not normally be required to review this item.

Items 4 and 5: Date of Birth and Sex.--The date of birth should be shown in item 4. However, the date of birth may not be shown if it is not available after the provider has made a reasonable effort to obtain it. (See §3507.8.) Six-digit numbers are used for the date of birth, e.g., 01/02/95 for January 2, 1895. This information is provided to assist in identifying the patient. The sex designation should be reviewed in conjunction with item 16, Diagnoses, to identify obvious inconsistencies.

Items 6, 7 and 8: Home Health Agency and Medical Record Identification.--The name and address of the home health agency and the health insurance provider number should be entered. These items may have been preprinted on all copies of the agency's supply of these forms. The intermediary should check the accuracy of these items.

The patient's medical record in item 8 may be shown by the agency if the agency assigns one and it is needed by the agency for association and reference purposes. The intermediary need not review this item.

Item 9: Attending Physician.--The name and address of the attending physician should be shown. The name should be that of the physician who established the plan and will certify or recertify the medical necessity of the services. If this item is omitted, it need not be obtained unless the intermediary requires such identification for any development deemed necessary.

Item 10: Date Care Started.--The date on which home health services began should be shown here.

Items 11 and 12: Name and Address of Institution, If Any, Caring For Condition Later Requiring Home Health Services and Verified Dates of Stay.--In order for home health visits to be paid



for on a posthospital basis, the physician's plan for treatment of the condition must be established within 14 days after discharge from a hospital after a stay of at least 3 consecutive days, (the day of admission is counted but not the day of discharge) or from an extended care facility to which Part A benefits were payable on his behalf. Since payments for extended care services cannot be made until January 1, 1967, a posthospital home health plan established before that date must be established within 14 days after discharge from a hospital after a 3-day stay regardless of whether the patient was discharged later from an extended care facility.

The name and address of the hospital or extended care facility should be entered in item 11 in all cases where it is applicable. However, the dates of stay in item 12 should be entered only when they are taken from official records. If this entry is omitted by the home health agency, the intermediary must request the institution to submit this information and enter the verified dates in item 12.

Under certain conditions payment may be continued under the original posthospital plan even though the patient has been institutionalized again or transfers to another home health agency. If the patient had received home health services prior to his most recent stay in a hospital or extended care facility and posthospital visits are being resumed under the original plan, the name and address of the agency furnishing the previous visits should be shown in item 11 and the inclusive dates of service, if verified, in item 12. If the patient received posthospital home health services from another agency and transferred to the agency submitting the bill for visits under the original plan, and the date of the first visit from this agency is within a year after the date of the last visit from the other agency, the name and address of the other agency should be entered in item 11 and the inclusive dates of service, if verified, in item 12.

Item 13: Date Home Health Plan Established.--The date on which the patient's attending physician made the plan for home health services should be shown here.

Item 14: Payment Source.--The agency will show all sources that will pay amounts of the bill which cannot be paid for by the

health insurance program. If a State public welfare agency will pay or has paid for such amounts, the name and address of the agency will be entered.

Item 15: Patient's Certification and Payment Request.--This item should have the patient's signature, or the signature of someone filing on behalf of the patient. Where someone files on behalf of the patient, an accompanying statement should be attached explaining the relationship of the signatory to the patient and the circumstances that made it impracticable for the patient to sign. (See § 3302.)

Where the patient's signature is by mark, the mark must be witnessed by someone who knows him. The witness's name and address would be shown.

If the bill submitted, however, is a subsequent bill, this item need not be completed unless there is an interruption of 60 days or more in visits furnished by the same agency or a transfer from one agency to another.

Item 16: Diagnoses.--All the diagnoses furnished by the physician to the agency should be shown. The primary diagnosis would be listed first. An essential part of this item is the information solicited regarding whether or not the condition was work-related. See §§ 3409 ff. for a description of the necessary considerations required in handling workmen's compensation involvement.

Where the billing is under hospital insurance (Part A) the diagnosis shown should include one which relates to any condition for which the beneficiary received inpatient hospital or posthospital extended care services during the related hospital or extended care facility stay. (See § 3121.2 and § 3326.)

Item 17: Statement Covers Period.--The beginning and ending dates of the period covered by this statement should be shown. The beginning date will normally be the date of the patient's first chargeable visit under either hospital insurance or medical insurance. If charges are being made under the medical plan, the beginning date should be no earlier than the patient's effective date of entitlement to medical insurance benefits, even though the care may have started before that date. If reimbursable services are furnished which are not charged as visits and are incurred before the first visit, the beginning date will be the date the services were first furnished.



For the ending date, the date of the last visit before death or termination of services, or, in the case of interim billing, the last visit for which current billing is being made should be shown.

Item 18: Dates of Visits--Show the dates of the first and last visits of the billing period as charged to the posthospital plan or the medical plan. When reviewing this item, it should be borne in mind that the hospital insurance plan pays for up to 100 visits in a 1-year period following the most recent discharge from a 3-day hospital stay, or if later, from an extended care facility entitled to payment under the plan.

The supplementary medical insurance plan pays for up to 100 visits in a calendar year.

Item 19  
& 20: Discharge Information--Item 19 should indicate whether at the end of the billing period the patient was discharged, died, is still receiving services, or his benefits are exhausted. The date of discharge or death, if applicable, is shown in item 20.

Item 21: Statement of Services Rendered--Based on the information furnished on the Start of Care Notice and other information, the intermediary will advise the agency on how visits are to be charged. If the first billing is under the posthospital plan, the Home Health Agency should continue charging visits to the posthospital plan until the patient is discharged or the allowable visits are exhausted, whichever occurs first. If the allowable visits under the posthospital plan are used up and the patient is still receiving services, subsequent visits should be charged to the medical plan if the beneficiary is entitled to medical insurance and has visits available for the current year. A new form should be used to switch from posthospital plan visits to medical plan visits, or vice versa.

Visits for other purposes than those specifically provided for in the law should not be shown as visits on this form. Some examples of **noncovered** visits are homemaker services and "meals-on-wheels." Posthospital plan and medical plan services should not be reported on the same billing form. Separate forms for each plan should always be used.

Any items or services which are covered as home health services under the law and which are furnished at a hospital, extended care facility, or rehabilitation center, but billed through the home health agency should be shown on

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the billing form as if those items or services were furnished directly by the home health agency itself.

The number of visits by qualified health workers should be shown by category. Visits are defined in § 3124 ff. If the specialty of the health worker is not shown in A through F (e.g., intern or resident), it should be shown in G. In addition, if the agency charges a separate fee for each service, the charges in A - G should be shown. If the agency charges a package fee for all types of services, the total units (visits, days, weeks, depending on how the charges are made) shown in H, and charge per unit of service shown in I.

The total visits and the total charges for visits will always be shown in J. K will be used to specify any additional charges which are not classified as visits and are not included in the visit charges, such as medical supplies and equipment, for which a separate charge is being made. Supplies or equipment of this nature should be shown in L.

If the patient paid any amount toward the deductible and/or coinsurance before the billing is submitted to your intermediary, the total amount paid by him or on his behalf should be shown in M.

Item 22: Computing Reimbursement Under Posthospital Plan--The computation may be made by the agency and reviewed by the intermediary or made solely by the intermediary.

Item A: The total charges from item 21-L made to the post-hospital plan should be entered here.

Item B: The agreed-upon reimbursement rate, which will be a percentage that the agency's charges bear to costs should be shown here. The intermediary should determine the appropriate percentage using the guidelines established by SSA.

Item C: The total charges should be multiplied by the reimbursement rate.

Item 23: Computing Reimbursement Under the Medical Plan--The intermediary may suggest that the agency not make this computation unless it knows that the patient's \$50 deductible is already met.

Item A: The amount of the deductible, if any, applicable to this bill should be entered here by the intermediary when the deductible has not been met.

- Item B: The entry in A should be subtracted from the total charges in C and the difference multiplied by 20 percent. This will be the coinsurance amount for which the patient is responsible.
- Item C: The total charges under the medical plan from line 21-L should be entered here.
- Item D: The reimbursement rate is entered here. It will be the same percentage that is used for the posthospital plan.
- Item E: The total charges should be multiplied by the reimbursement rate.
- Item F: Any applicable deductible should be subtracted from the figure in E.
- Item G: The figure in F should be multiplied by 80 percent.
- Items H and I: The intermediary will use these items when it is determined that the patient has overpaid the deductible and coinsurance, and is refunding the overpayment to him.

Certification and Signature Line--An agency representative must certify that the required physician's certifications and recertifications are on file and the date the bill was forwarded to the intermediary.

Approved By and Date Approved--The signature of the intermediary official approving the bill and the date approved should be entered in the appropriate items.





3800 - Transmittal and Maintenance of  
Claims Records

3700 - Payment and Postpayment  
Procedures



## CHAPTER VIII

## PAYMENT AND POSTPAYMENT PROCEDURES

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## 3701. NOTICE OF PAYMENT

Under the health insurance law, payments to providers must be made not less often than monthly. A notice of payment is to be sent to the provider when payment is made. The intermediary should also notify the provider of the patient's verified liability. This is especially important where the provider chooses to wait for Part B outpatient and home health benefits to be paid before collecting any amount of the deductible and coinsurance from the patient. The provider will not know the exact status of the patient's deductible unless the patient presents a utilization notice showing that the deductible was met in the year. If the provider waits for the benefit payment before collecting from the patient, there would be fewer erroneous bill collections which would have to be refunded. Although the method and format of the notice is left up to the intermediary, the verification of the patient's liability should be included on the voucher which explains the amount of the benefit check to the provider.

## 3702. BENEFIT CHECKS

The payment checks will contain the legend:

"For Health Insurance--Social Security Act."

If an intermediary is also administering the Title XIX program for a State, the intermediary will not combine payments under Titles XVIII and XIX in a single check.

## 3705. DENIALS - NOTICE TO PROVIDER

The provider should submit a bill whenever the beneficiary signs a request for payment, even when the provider knows that no payment will be possible.

Whenever the intermediary denies a signed request for payment, the provider must be informed in writing and in detail why no payment will be made.

## 3708. ADJUSTMENTS

If the intermediary notes an error or an item with which it disagrees on the provider bill, the provider will be contacted and the matter clarified. If necessary, the provider will submit a corrected bill to the intermediary.

## 3710. CORRECTED BILLS

When the provider finds it necessary to correct a bill because of an adjustment request or on its own initiative, it will reproduce and submit to the intermediary, three copies of the previously submitted bill and make the necessary corrections on two of them. The corrected copies should have the words "DEBIT--ADJUST" printed

in large red letters, in the extreme upper right margin and the third copy should have the words "CREDIT--CANCEL" printed in large red letters, in the extreme upper right margin. A cancellation of a previous bill requires the copy of the original bill to be annotated in the extreme upper right-hand margin with the phrase "CANCEL ONLY."

If the provider submits a corrected bill before payment on the initial bill is made, and the latter amount is determined to be the proper charge, payment will be made on the corrected bill.

However, if the provider submits a corrected bill after payment has been made and the charges on the later bill exceed the charges on the earlier bill, an explanation should be requested from the provider before the additional amount is paid if an explanation does not accompany the bill. If the charges on the later bill are less than the earlier bill, the intermediary should see that the overpayment is recovered from the provider or necessary adjustment made. All adjustments or changes to SSA records will be made by complete credit action first and then followed by the necessary debit action.

#### 3712. OVERPAYMENTS AND UNDERPAYMENTS TO PROVIDERS

The intermediary will determine the amount to be paid periodically to providers of services on an estimated basis. Necessary adjustments with respect to overpayments and underpayments will be made when the actual costs have been determined. While overpayments and underpayments to providers of services will ordinarily be adjusted in this manner, in some situations overpayments or underpayments may be corrected by direct refund or payment if this method is found to be more convenient.

#### 3713. INDIVIDUAL RESPONSIBILITY FOR OVERPAYMENTS TO PROVIDERS

Any payment under the law to any provider with respect to items and services furnished an individual shall be regarded as a payment to the individual. Where more than the correct amount is paid to the provider for items and services furnished to an individual and the Social Security Administration determines that, within a reasonable period (to be specified later), the excess cannot be recouped from the provider, the adjustments will be made by decreasing subsequent social security or railroad retirement benefits payable to the beneficiary (or to his survivors, if the recoupment is not completed before he dies) unless the Administration determines the overpayment is to be waived.



If the intermediary determines that an overpayment cannot be recouped from the provider (within a period to be later specified), a report of the amount of the overpayment, the circumstances causing the overpayment, an explanation of the intermediary's recovery efforts and the reason(s) the overpayment could not be recovered should be forwarded to the Bureau of Health Insurance, Division of Policy and Standards, in Baltimore.

#### 3717. UTILIZATION NOTICES

There are three types of utilization notices to provide the beneficiary with limited bill data, a record of additional benefits available, and to confirm payment of his covered expenses under the health insurance program. These notices are:

Notice of Hospital Utilization, Form SSA-1533;

Notice of Medical Utilization, Form SSA-1533A; and

Explanation of Outpatient Hospital Benefits.

#### 3718. NOTICE OF HOSPITAL INSURANCE UTILIZATION, FORM SSA-1533

This notice will be prepared and mailed by SSA to the beneficiary as soon as a paid Part A bill for inpatient hospital, extended care, or home health services has been recorded on the HI eligibility and utilization record (See Exhibit 1).

##### A. Entries on Form SSA-1533

1. Name and Address, Date, and Claim Number.--The name and address of the beneficiary, or his representative, will be shown in the address box. Where the bill indicates the beneficiary is deceased, and there is no representative, the form will be addressed to "THE ESTATE OF" the beneficiary.

The date the form is prepared and the health insurance claim number will be shown in the spaces provided.

2. Types of Services.--As applicable, "INPATIENT HOSPITAL," "EXTENDED CARE," or "HOME HEALTH" will be entered.

3. Dates Covered By Bill.--(Self-explanatory.)

4. Institution or Agency Providing Service.--The name and address of the provider will be shown.

5. Office Which Handled Your Claim.--The name and address of the appropriate intermediary will be shown.

6. Exceptions.--The exceptions shown will represent only covered expenses which cannot be paid by **hospital insurance** (i.e.,

deductibles and coinsurance). No entry will be made regarding noncovered expenses, since charges for the physician component are not identified on the billing form nor may other noncovered expenses be shown (e.g., private-duty nurse and personal comfort items).

7. Record of Additional Benefits Available.--This section of the form will indicate services used during the spell of illness involved and the services remaining. Where the current bill is for inpatient psychiatric services, the number of days remaining toward the lifetime limit will be indicated.

A statement will always be entered as an aid to the beneficiary in determining when a new spell of illness will begin. The text of the statement will depend on whether SSA records show the beneficiary is or is not in a hospital or extended care facility.

Where the beneficiary has Part B coverage and there has been prior utilization of home health visits, or where the Part A visits have been exhausted, a statement regarding the status of the Part B home health visits will be added.

8. Information on Reverse Side of Form.--The preprinted data on the reverse side of the form furnishes general information about hospital insurance. The paragraph about additional benefits available is, in effect, a disclaimer in the event the notice does not reflect current status because of another outstanding bill or utilization not yet recorded.

B. Disallowance Letter-Hospital Insurance.--SSA will send a disallowance letter in lieu of a Notice of Utilization in those instances where the beneficiary has requested payment on his behalf for hospital insurance benefits but no payment can be made. Some examples are as follows:

1. The benefits involved have been exhausted for the spell of illness.

2. Beneficiary does not meet the hospitalization and/or 14-day requirement for ECF or home health services.

3. Home health benefits are terminated by a new spell of illness.

4. Services furnished by a nonparticipating provider.

5. Services in an ECF after paid services in Christian Science ECF or vice versa during the same spell of illness.

6. No payment due to utilization review provisions.

7. Expenses covered by a workmen's compensation program.

8. Only noncovered services received.

3719. NOTICE OF MEDICAL INSURANCE UTILIZATION, FORM SSA-1533A  
This notice will be prepared and mailed by SSA to the beneficiary as soon as a Part B bill for home health services is recorded on the HI eligibility and utilization record (See Exhibit 2).

A. Entries on Form SSA-1533A.--The information on this form is similar to that of the SSA-1533 except for the following items.

1. Computation of Benefits.--The entries in this part of the form will show the deductible and coinsurance on this particular bill.

2. Status of Medical Insurance Record.--This part of the form will contain statements that the \$50 deductible has been met for the year, and the number of home health visits used and remaining for the year.

B. Disallowance Letter-Medical Insurance.--Where the beneficiary has requested payment for medical insurance services but no payment can be made, the Part A intermediary will prepare and forward a disallowance letter to the beneficiary. In these cases, a notice of utilization will not be prepared by SSA.

The law requires a fair hearing for any person enrolled in the medical insurance program when a request for payment is denied, or not acted upon with reasonable promptness, or when the amount of payment is in controversy. Therefore, the disallowance letter should include a statement of this hearing requirement.

If the request for payment is denied because the individual has not yet met the \$50 deductible, the individual will be informed of the amount of incurred expenses toward the \$50 deductible.

3720. EXPLANATION OF OUTPATIENT HOSPITAL BENEFITS FORM  
Where the medical insurance deductible status is not known at the time the hospital collects from an individual for outpatient hospital services, the Part A intermediary will refund any overpayment



directly to the beneficiary. In addition, it is essential that the individual be informed of the status of his medical insurance deductible, where applicable, as soon as his claim is reviewed and a determination made regarding payment to the hospital involved. Therefore, in all claims for outpatient hospital services, whether covered by hospital insurance and/or medical insurance, the Part A intermediary will prepare the explanation of benefits notice and forward it to the beneficiary.

Three separate forms are used for this purpose: one for outpatient services where both hospital and medical insurance benefits are involved, one for outpatient services involving hospital insurance benefits only, and one for outpatient services involving medical insurance benefits only. While samples of these forms were furnished, the forms will not be issued by the Social Security Administration at this time. After any necessary changes or insertions are made, these forms should be reproduced locally by the Part A intermediary.

#### 3720.1 Selecting Appropriate Form for Use

A. Hospital Insurance Form.--This form should be used in those instances where only Part A charges are shown on the billing form and the patient is not entitled to medical insurance. (If the beneficiary has requested payment but no Part A benefits are payable, a notice by the Part A intermediary is not required; when the billing form is received in such cases, SSA will prepare and forward a disallowance letter to the beneficiary.)

B. Medical Insurance Form.--This form should be used in those instances where only Part B charges are shown on the billing form (i.e., no diagnostic study charge under Part A is involved).

C. Hospital and Medical Insurance Form.--This form should be used any time Part A charges are shown on the billing form and the individual is entitled to medical insurance, whether or not Part B charges are shown on the billing form.

#### 3720.2 Completing Explanation of Benefits Form

A. The entries to be made on the form are self-explanatory and in most cases can be merely transcribed from the related Form SSA-1483, Outpatient Hospital Billing. However, in describing the services involved, consideration should be given to striking a balance between being specific enough to enable the beneficiary to identify the service, yet general enough to avoid revealing sensitive information

which the physician might not want the patient to know. The entry in "Hospital Insurance Benefits" and/or "Medical Insurance Benefits" should always represent the total covered charges less the total payable by the beneficiary; i.e., the form should always balance.

B. The remarks section will be used to explain why payment cannot be made under hospital or medical insurance, or why no payment can be made for specific services or supplies which are not covered. Sample paragraphs for use in the remarks section are as follows:

1. No Payment Under Hospital Insurance.--"No payment can be made under the hospital insurance plan since the total charges do not exceed the first \$20 you must pay for each diagnostic study."

2. No Payment Under Medical Insurance.--"No payment can be made under the medical insurance plan until you have incurred \$50 expenses."

"Our records indicate that your medical insurance coverage has been terminated because premium payments have not been received for your account; therefore, no payment can be made under the medical insurance plan."

"It has been determined that there is a reasonable likelihood that a workmen's compensation payment will be made for the medical services or supplies for which you requested payment. The law does not permit any payment to be made if workmen's compensation payment is expected. Your case may be reopened if workmen's compensation does not make payment."

The above paragraphs may be included on the form when either some hospital or some medical insurance benefit is payable. However, if the entire claim is being disallowed, intermediaries may prefer to use a separate disallowance letter. Such action by the intermediary is appropriate to its role as a Part B intermediary for provider services. When a disallowance letter is used, it is important that the letter clearly state the reasons for the denial, the place where the beneficiary can secure additional information or explanations, and a statement of the period within which a request for a hearing may be filed after the date of the notice.

3. Noncovered Charges.--"Charges for (description of service or supplies) are not covered under the ('health,' if general exclusion; 'hospital,' if excluded under hospital plan) insurance program. Therefore, no payment can be made for these expenses."

C. Sample paragraphs for use in the medical insurance deductible status block are as follows:

"Your \$50 deductible has been met for (year)."

"You have incurred \$\_\_\_\_\_ toward the deductible for the year 19\_\_."





DEPARTMENT OF  
HEALTH, EDUCATION, AND WELFARE  
SOCIAL SECURITY ADMINISTRATION  
BALTIMORE, MARYLAND 21235

NOTICE OF HOSPITAL INSURANCE UTILIZATION

NAME AND ADDRESS OF THE BENEFICIARY  
OR REPRESENTATIVE OF THE BENEFICIARY

DATE:  
HEALTH INSURANCE CLAIM NUMBER:

The bill for HOSPITAL INSURANCE services described below was recently submitted under your health insurance claim number and recorded to your account.

TYPE OF SERVICES	DATES COVERED BY BILL		NUMBER OF HOME HEALTH VISITS INCLUDED
	FROM	TO	
Institution or agency providing services			
Office which handled your claim			

For each spell of illness, your HOSPITAL INSURANCE under Medicare pays the costs of all covered services, with certain exceptions. These are the exceptions for this bill:

RECORD OF ADDITIONAL BENEFITS AVAILABLE

As of the date of this notice, your record of inpatient hospital and extended care benefits for the spell of illness involved and your record of home health benefits is as follows:

INPATIENT HOSPITAL DAYS			EXTENDED CARE FACILITY DAYS			HOME HEALTH VISITS		
USED THIS BILL	USED TO DATE	REMAINING	USED THIS BILL	USED TO DATE	REMAINING	USED THIS BILL	USED TO DATE	REMAINING

If you have to use HOSPITAL INSURANCE services again, please take this latest notice with you and show it, along with your Health Insurance card, to the agency or institution furnishing the services.

*Robert M. Ball*  
Robert M. Ball  
Commissioner of Social Security

PLEASE READ THE OTHER SIDE OF THIS NOTICE FOR IMPORTANT INFORMATION.

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KEEP THIS NOTICE AS A RECORD OF HEALTH INSURANCE SERVICES  
RECORDED TO YOUR ACCOUNT

GENERAL INFORMATION

Information about your Health Insurance under Social Security is furnished in "Your Medicare Handbook" which you received earlier. For example, the definition of a spell of illness is furnished on page 10 and inpatient hospital benefits are discussed on pages 5 and 6. If you have any questions which are not answered in "Your Medicare Handbook," the people in your social security office will be pleased to help you.

A hospital, home health agency, or extended care facility which is participating in the Medicare program has agreed not to charge you for services *paid* for by your HOSPITAL INSURANCE. Therefore, the covered expenses which were *not paid* for by your HOSPITAL INSURANCE (if any) are listed as exceptions on the other side of this form. You may have received a separate bill for these expenses. In addition, you may receive a separate bill for services *not covered* by your HOSPITAL INSURANCE such as a private room furnished at your request, private duty nurses, personal comfort items, and physicians' services. (However, if you have MEDICAL INSURANCE, it will help pay your doctor bills.)

If you have other health insurance, this notice may be useful in claiming benefits payable by the other health insurance organization.

The people in your social security office will be glad to answer any questions you may have about this notice. If you believe that your HOSPITAL INSURANCE should have paid more of the bill, you can ask the office which handled your claim (shown on the other side of this form) for an explanation.

If you visit your social security office, be sure to take along all papers you have concerning the bill involved. Always show your health insurance claim number when writing about your claim.

The Record of Additional Benefits Available, shown on the lower half of the other side of this form, is based on the latest information we have. If you recently received HOSPITAL INSURANCE services other than those shown on this form, they will be recorded to your account shortly after we receive a record of services provided. You will then receive another Notice of Hospital Insurance Utilization, furnishing a new record of benefits available.



DEPARTMENT OF  
HEALTH, EDUCATION, AND WELFARE  
SOCIAL SECURITY ADMINISTRATION  
BALTIMORE, MARYLAND 21235

NOTICE OF MEDICAL INSURANCE UTILIZATION

NAME AND ADDRESS OF THE BENEFICIARY  
OR REPRESENTATIVE OF THE BENEFICIARY

DATE:

HEALTH INSURANCE CLAIM NUMBER:

The bill for MEDICAL INSURANCE services described below was recently submitted under your health insurance claim number and recorded to your account.

TYPE OF SERVICES	DATES COVERED BY BILL		NUMBER OF HOME HEALTH VISITS INCLUDED
	FROM	TO	

Institution or agency  
furnishing services

Office which handled  
your claim

Each year, as soon as your covered medical expenses go over \$50, your MEDICAL INSURANCE will pay 80 percent of the reasonable costs or charges for all additional covered services for the rest of the year. The computation of MEDICAL INSURANCE benefits for this bill is shown below.

TOTAL COVERED CHARGES	AMOUNT TOWARD \$50 DEDUCTIBLE	20% PAYABLE BY BENEFICIARY	TOTAL PAYABLE BY BENEFICIARY

STATUS OF MEDICAL INSURANCE RECORD

As of the date of this notice, the status of your MEDICAL INSURANCE record is as follows:

*Robert M. Ball*  
Robert M. Ball  
Commissioner of Social Security

PLEASE READ THE OTHER SIDE OF THIS NOTICE FOR IMPORTANT INFORMATION.

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**KEEP THIS NOTICE AS A RECORD OF HEALTH INSURANCE SERVICES  
RECORDED TO YOUR ACCOUNT**

**GENERAL INFORMATION**

Information about your Health Insurance under Social Security is furnished in "Your Medicare Handbook" which you received earlier. If you have any questions which are not answered in "Your Medicare Handbook," the people in your social security office will be pleased to help you.

If you have a problem or question about the way this claim was handled, you should get in touch with the office which handled your claim (shown on the other side of this notice). That office will be glad to give your request full consideration and will provide you with additional information as to what action you may take if you are still not satisfied.

Always show your Health Insurance claim number when writing about your claim.

If you have other health insurance, this notice may be useful in claiming any benefits payable by the other health insurance organization.

This notice includes only information about MEDICAL INSURANCE services which were furnished by the institution or agency identified on the other side of this notice. If you have requested payment for medical expenses other than those shown on this form you will receive a separate notice.

This notice can be used to indicate the status of the \$50 deductible to your doctor or anyone else from whom you request services.

Disclosure of Information**3760. DISCLOSURE OF INFORMATION--GENERAL**

In the administration of the health insurance law, the Administration, intermediaries, providers of service, and State agencies acquire information about beneficiaries and about institutions and organizations which are participating, or have been denied participation, in the program. This information, for the most part, is acquired under circumstances in which the individual, institution, organization, etc., furnishing the information expects it to be kept confidential. Section 1106 of the Social Security Act and the rules and policies formulated by the Administration under Regulation No. 1 recognize the basic legislative pledge of confidentiality given the public.

**3762. THE PROHIBITION AGAINST DISCLOSURE**

Section 1106 of the Social Security Act prohibits disclosure of any file, record, report, or other paper, or any information obtained at any time by the Secretary or an officer or employee of the Department of Health, Education, and Welfare in the course of discharging his duties under the Social Security Act, except as prescribed by regulations. The same prohibition applies to information received from the Secretary or an officer or employee of the Department. The routine medical records of a patient in the possession of a provider or physician are not bound by the prohibition or by Departmental rules and regulations concerning confidentiality simply because the patient is entitled to benefits under this program. These records, however, may be subject to applicable State or local laws, or hospital rules governing disclosure.

The prohibitions noted above apply also to any agency, organization, e.g., an intermediary, or institution, or any of its officers or employees, in the fulfillment of a contract or agreement with the Secretary.

The prohibition also relates to any information received from the Department or an intermediary by any person or entity which furnishes services under arrangements with a provider; or accepts an assignment under the medical insurance program.

**3764. THE AUTHORITY FOR DISCLOSURE**

Regulation No. 1 contains the basic authorization for disclosure of information obtained in the administration of the program, from which rules and policies have been developed. The general rule is that information about an individual, organization,

institution, etc., obtained in the administration of the program may not be disclosed without the authorization of the individual, organization, institution, etc., to whom the information relates. Medical information relating to an individual will generally be disclosed under more restrictive conditions than other information and where permitted, may be furnished only upon the authorization of the source of the information as well as the individual. Specific exceptions to this general rule are set out in detail in the following sections; however, as far as the program is concerned, information about an individual, organization, or institution may be disclosed without the authorization of the individual, organization, or institution, when the disclosure is necessary in connection with any claim or other proceeding under the law.

Disclosure of information for other than program purposes will be made only if disclosure is authorized by Regulation No. 1 and is consistent with the proper and efficient administration of the program.

3765. DISCLOSURE NECESSARY FOR PROPER ADMINISTRATION OF THE HEALTH INSURANCE PROGRAM

A. Information About an Individual

Disclosure of any record, report, or information about an individual may be made, without the authorization of the individual, in connection with any claim or other proceeding under the Act when such disclosure is necessary for the proper performance of the duties of:

1. Any officer or employee of the Department; or
2. Any officer or employee of a State agency, intermediary, provider of services or other agency or organization participating in the administration of the program by contract or agreement in carrying out such contract or agreement.

B. Information About Hospitals, Extended Care Facilities, Home Health Agencies

Information about a hospital, extended care facility or home health agency, as well as information about an independent laboratory, may be disclosed without authorization by the institution or organization when such disclosure is required for the proper performance of the duties of:

1. An officer or employee of the Department;
2. An officer or employee of an intermediary; or



3. An officer or employee of a State agency when necessary to carry out his duties under State law in the licensing or approving of hospitals, extended care facilities, home health agencies, or independent laboratories.

Information obtained in the provider certification process is not to be disclosed to those not included in the above three categories. This prohibition encompasses information such as the fact that a particular identified hospital has or has not applied for participation in the program; the progress that a hospital is making towards being approved; that survey findings on a particular hospital are favorable or unfavorable; that a hospital is certified for approval but is deficient in some respects; or that a particular hospital has been found not in compliance with the conditions or participation, etc. Anyone not among the above three categories requesting information about the status of an institution or agency which is not on the list as a participating provider of services is to be referred to the institution for the information regarding its status.

**3767. DISCLOSURE OF INFORMATION TO AN INDIVIDUAL OR HIS  
AUTHORIZED REPRESENTATIVE**

**A. Nonmedical Information**

Nonmedical information directly relating to an individual may be disclosed, in form and detail consistent with proper and efficient administration of the program, to the individual or his authorized representative when reasonably necessary for a program purpose. For all other purposes disclosure is conditional upon administrative feasibility.

**B. Medical Information**

Medical information about an individual obtained in the administration of the program may be disclosed, in form and detail consistent with proper and efficient administration of the program, to the individual or to his authorized representative when disclosure is reasonably necessary for a program purpose. However, medical information about the individual is not to be disclosed to him if knowledge of it would be detrimental to him.

Disclosure of medical information for other than a program purpose is not permitted under the present regulations, but the Administration is considering the question of amending the regulations to provide for disclosure for other than a program purpose when the information is necessary for a determination of the benefits the individual may be eligible for under another health

insurance program; however, such disclosure would be made only if the source of the medical information authorizes it.

3768. DISCLOSURE TO THIRD PARTIES FOR OTHER THAN PROGRAM PURPOSES

A. Nonmedical Benefit Information

Nonmedical benefit information about an individual may be disclosed for other than a program purpose, to persons or organizations designated by the individual, if the individual authorizes disclosure, and if disclosure is consistent with the proper and efficient administration of the Act.

B. Medical Information

Disclosure of medical information for other than a program purpose is not permitted under the present regulations, but the Administration is considering the question of amending the regulations to provide for disclosure when the information is necessary for a determination of the amount of benefits or services an individual may be eligible for under a hospital or medical insurance plan, a group health plan, a complementary insurance plan, etc., which has been determined to be consistent with the purposes and objectives of the health insurance law, but only if the source of such medical information or, if the source is not available, a physician in the employ of the Department, consents to disclosure and the individual involved or his authorized representative consents to disclosure.

C. Information an Intermediary is not Authorized to Use or Disclose

In the light of the above rules, a participating intermediary which is also writing complementary insurance, or administering an employee or union group health plan, may not in its capacity as intermediary release information obtained in connection with the administration of the health insurance program to itself in its capacity as private insurance writer or administrator, for nonprogram activities. Without first satisfying the appropriate rules discussed above, the intermediary, for example, may not use information obtained in the administration of the program for making payment under its complementary insurance plan. Further, under no circumstances may an intermediary use the knowledge of an individual's entitlement under the health insurance program, obtained in the course of performing its program functions, for purposes of sales leads; use entitlement or benefit utilization information for purposes of dropping an individual from a group health insurance plan; or integrate an individual's complementary insurance record with his health insurance record.

**3770. DISCLOSURE TO STATE AGENCIES ADMINISTERING PROGRAMS  
RECEIVING FEDERAL GRANTS-IN-AID**

**A. Nonmedical Benefit Information**

Nonmedical benefit information such as entitlement, benefit payments, or benefit utilization relating to an individual may be disclosed to any officer or employee of a State agency charged with the administration of grants-in-aid programs under titles I, IV, V, X, XIV, XVI, or XIX of the Social Security Act without the authorization of the individual or his authorized representative.

**B. Medical Information**

The general rule is that medical information relating to an individual (and obtained in the administration of the health insurance program, may be disclosed to a State agency administering the grants-in-aid program cited above, with written authorization of the beneficiary and the physician or provider.

**3773. DISCLOSURE OF STATISTICAL AND OTHER INFORMATION**

Statistical data and similar information which does not relate to any identifiable person or persons and which can be compiled from the records regularly maintained for administrative purposes may be disclosed if efficient administration permits disclosure. Statistical data and similar information shall be disclosed by intermediaries, State agencies, or any other organization, institution, or person engaged in performing program functions, only after the request for disclosure has been specifically approved by the Social Security Administration.

**3774. ADMINISTRATIVE RULES RESTRICTING DISCLOSURE OF INFORMATION**

Manuals prepared for the use of organizations performing functions under contract with the Administration, staff instructions, inter-office correspondence, and other memoranda and materials relating to internal operating procedures are confidential and not to be disclosed to the public. This restriction is based upon administrative decision and is in conformance with the applicable rules and requirements of the Administrative Procedure Act.

**3776. AUTHORITY FOR REFUSAL TO DISCLOSE INFORMATION**

When a request for information is received, disclosure of which is prohibited under the preceding sections, it is to be declined on the basis of the provisions of section 1106(a) of the Social Security Act, as amended, and Regulation No. 1 of the Social Security Administration (20 CFR 401). If any person, or an officer or employee of any organization, institution, etc., described in the preceding section, is served with a subpoena or other compulsory process requiring the production of records



or information the disclosure of which is prohibited, he will decline to produce the records or information, basing his refusal on section 1106 of the Social Security Act and Regulation No. 1 of the Social Security Administration (20 CFR 401). If a subpoena is served on an officer or employee of any organization described above or any other person who is prohibited by section 1106 from disclosing the requested information, the Regional Representative, Health Insurance, is to be notified immediately.

3778. FAILURE TO COMPLY WITH THE RULES RELATING TO DISCLOSURE OF INFORMATION OBTAINED IN THE ADMINISTRATION OF THE ACT  
Section 1106(a) of the Act provides that any person who violates the disclosure provisions shall be deemed guilty of a misdemeanor and, upon conviction thereof, shall be punished by a fine not exceeding \$1,000, or by imprisonment not exceeding 1 year, or both.

Appeals

## 3780. QUESTIONS INVOLVING ENTITLEMENT

Questions and complaints involving the individual's entitlement to hospital or medical insurance benefits and cases in which there is doubt as to jurisdiction must be referred to the Social Security Administration for resolution.

The intermediary should acknowledge such questions and complaints and inform the enrollee that due to the nature of the subject, the matter must be handled by the Social Security Administration.

## 3782. PROTESTS AND APPEALS FROM PAYMENT DETERMINATIONS UNDER HOSPITAL INSURANCE

A. Provider Protests. The intermediary and its providers should attempt to resolve by direct contact any differences involving payment for services whether arising from the application of the cost formula or the amount payable in a specific case. While no appeals process has been provided for providers from intermediary determinations involving payment, provider complaints and protests will be considered in SSA review of the intermediary's application of the cost formula or its compliance with the other terms of its agreement with the Government.

B. Beneficiary's Appeal Rights. An individual dissatisfied with any determination as to the amount of benefits payable on his behalf under the hospital insurance plan is entitled to a reconsideration of his claim by the Social Security Administration. Procedures for review of claims are under development. Should the individual's dissatisfaction continue following the reconsideration determination, he may request a hearing if the amount in controversy is \$100 or more. If the amount in controversy is \$1000 or more, the individual is entitled to court review of the claim if he is dissatisfied with the hearing decision.

## 3790. PROTESTS, REVIEW, AND "FAIR HEARING"--SUPPLEMENTARY MEDICAL INSURANCE

Since intermediaries administering the hospital insurance program may also be making payment for medical insurance items and services furnished by and under arrangements with providers, the intermediary must be prepared to handle protests and furnish the reviews and hearings necessary under the supplementary medical insurance program. It is anticipated that there will be only a small number of protests involving Part B provider services claims.

An individual enrolled under the medical insurance program is to be provided with the opportunity for a fair hearing by the medical insurance intermediary when he is dissatisfied with the intermediary's determination denying a request for payment, or with the amount of the intermediary payment under Part B. (The intermediary which makes payment of physician's bills will provide the fair hearing for beneficiaries whose protests concern payment for the services of physicians, including provider-based physicians, and other nonproviders. This intermediary will also conduct the fair hearing on complaints of assigner physicians and suppliers.) The law does not provide an appeal to the Social Security Administration from an intermediary's decision or judicial review of the "fair hearing" decision.

A number of governing principles have been established to serve as guidelines for intermediaries to assure that an enrollee under Part B will receive a fair hearing. In view of the variation in type of organizations which qualify as intermediaries to make payment under Part B, it is desirable that the Administration provide general guidance as to the requirements for a fair hearing. Though each intermediary will establish its own methods for providing a fair hearing, the Administration will spot review "fair hearing" decisions to assure that the methods and procedures employed are, in fact, consistent with the governing principles for a fair hearing set by the Administration. Through this nonadjudicative survey of decisions, the Administration will be in a position to advise and consult with intermediaries to assist them in maintaining quality determinations and assure that enrollees receive a fair hearing. The Administration will give every assistance to intermediaries to help them set up the fair hearing procedure.

### 3793. INFORMAL REVIEW

Intermediaries will institute an informal review procedure as a prerequisite to the fair hearing. An informal review procedure, which is less costly and a more expeditious device for handling complaints than a formal hearing, is particularly appropriate for handling enrollee benefit determination complaints arising under Part B, since relatively small amounts of money will be involved in most cases. Most, if not all, intermediaries have experience with some type of informal procedure for handling complaints and the Administration expects that they will, therefore, have no difficulty in adapting to the informal review which is to be provided under the medical insurance program.



An enrollee must be notified in writing, at the time an intermediary makes a determination with respect to a request for payment for Part B services furnished the enrollee, of his right to question the intermediary's decision and the time limit, if any, within which the review must be requested. The enrollee must be promptly advised of the decision resulting from the informal review, of his right to request a fair hearing if he is not satisfied with the review determination, and the time limit, if one has been established, within which the hearing is to be requested. The following represents the essential elements necessary to an adequate informal review.

A. Notice of the right to question an adverse decision of the intermediary should be provided to the beneficiary at the time the intermediary acts on a request for payment. The notice of the claims action should contain an appeals paragraph such as the following. "If you have any question with regard to the action taken on this claim, please write to ( intermediary )." The beneficiary may also be referred to the local district office for assistance in writing out his complaint. The district office staff will give the beneficiary general program information and if he wishes to request a review of the decision, will help to phrase his complaint; however, they will not give any opinions as to the decision made in the particular claim.

B. Provision should be made for the informal review of disputed claims in the claims processing unit of the intermediary; however, an individual other than the one who made or participated in making the initial determination should perform the review.

C. The purpose of the informal review is to provide a new, independent, and critical review of the claim. The reviewer should not be influenced by the initial determination, but should, instead, review each aspect of the claim independently and arrive at his own conclusions. He should review not only the point at issue, but, the entire claim bearing in mind that the intermediary is on notice of dispute.

D. The beneficiary is to be given an opportunity to submit any relevant and material evidence. The reviewer should request additional evidence from the beneficiary and/or the physician, provider or other supplier of services if he finds it necessary. The beneficiary is to be instructed to submit evidence and statements in writing by mail or through his local Social Security Administration district office. Since one of the purposes of

instituting the informal review is to cut down unnecessary costs, the review will not provide for personal appearance and testimony by the beneficiary and face-to-face contact with the beneficiary at this stage of the claim process should be discouraged. If personal contacts are necessary, they should be made by Social Security Administration district office personnel.

E. The beneficiary is to be sent notice of the review determination setting out the bases for the determination. He is also to be notified of his right to a fair hearing if the review determination is an adverse one.

F. All intermediary actions in the review of a claim are to be fully documented and the file should include all correspondence, papers, requests, reports, etc., arising out of the claims review process. This file will be necessary for the conduct of the fair hearing, if requested. The intermediary is to make the file available to the Social Security Administration, if so requested.

#### 3795. FAIR HEARING

The fundamental purpose of a fair hearing is to provide an individual, dissatisfied with what he considers to be an adverse decision with respect to his claim for payment, an opportunity to present the reasons for his grievance and to afford him an impartial review based on the substance of his claim.

The principles enumerated below are to be applied by intermediaries in setting up the fair hearing required by the law to handle complaints by individuals dissatisfied with the informal review determination.

3795.1 Notice of Right to a Hearing.--As stated in the preceding paragraph, the notice of an adverse informal review decision must give the individual notice of the right to a fair hearing, the place and manner of requesting the hearing, and, if any, the time limit for requesting it.

To provide an enrollee a reasonable period of time in which to request a hearing, a period of at least 6 months after the notice of informal review must be allowed in which the individual can register a protest. A request for a hearing is any clear expression by the enrollee (or by a person acting on his behalf) to the effect that he is dissatisfied with the intermediary's determination regarding his claim for Part B benefits and wants an opportunity to present the matter to a higher authority.



3795.2 Notice of Time and Place of Hearing.--An enrollee who requests a fair hearing must be given adequate written notice of the time and place set for the hearing, information as to the specific issues to be determined and the matters on which findings will be made and conclusions will be reached. The notice will be given as promptly as possible after receipt of the request for a hearing. Where the hearing was requested by a person on behalf of the enrollee, notice must also be given to that person.

Consistent with public interest and efficient execution of the program duties of the intermediary, the hearing is to be scheduled for a time and at a place convenient to the enrollee and his representative, if any. The notice of the hearing is to be given sufficiently in advance of the date set and is to contain sufficient information about the hearing procedure (including the enrollee's right to representation) for effective preparation for the hearing.

A request for a hearing may be withdrawn only by the enrollee or his authorized representative and the withdrawal must be in writing. A request for a hearing may be considered abandoned if neither the enrollee nor his representative appears at the time and place set for the hearing and no reply is received within a reasonable time (10 days) to a notice of inquiry to the enrollee and his representative.

3795.3 Hearing Officer.--The hearing is to be conducted by a competent, qualified and impartial individual. The hearing officer is to be an individual who has not been involved in any way with the determination in question and has neither advised nor given consultation on the enrollee's request for payment which is the basis for the hearing. The hearing officer should be an attorney or other qualified individual with ability to conduct formal hearings and with some understanding of medical matters and terminology, and a thorough knowledge of the program and the regulations issued thereunder.

3795.4 Hearing Procedures.--The hearing procedure must provide an opportunity for the enrollee to appear in person and, if he desires, to be represented by legal counsel or by any other qualified individual. The enrollee may, however, forego the opportunity to appeal personally or through a representative. An enrollee and/or his representative must have the opportunity to offer oral and written evidence to examine and reply to evidence



relied upon by the intermediary as the basis for its action, and to present and examine witnesses. The rules of evidence established for the hearings procedure must offer sufficient latitude so that all relevant and material evidence can be accepted and considered without regard to whether it would be admissible under the rules of evidence applicable to court procedures.

3795.5 Hearing Decision.--The hearing officer must base his decision on the record, that is, the stenographic record of the hearing, documents, requests, papers and other written evidence. The record is to be made available to the enrollee or his representative for examination. If the beneficiary wishes to have a transcript of the stenographic record, it will be made available to him if he pays the cost of the preparation. Written notice of the hearing officer's decision and the basis for the decision must be furnished the enrollee as promptly as possible after the close of the hearing.

3795.6 Issues for Determination at a Fair Hearing.--The "fair hearing" procedures are to be utilized only to settle issues arising from certain determinations by the intermediary involving Part B benefits. These would include issues as to the deductible; covered services; the number of home health visits used; the timely execution and filing of a request for payment; whether a beneficiary is entitled to have payment made under Part A instead of Part B; whether a physician's certification has been properly obtained and the medical necessity of the services. The intermediary may not make determinations as to an individual's basic entitlement under the supplementary medical plan; or whether an institution furnishing services meets the conditions for participation or coverage of services; or whether charges made by a provider are reasonable.

Intermediaries should institute procedures to assure that appropriate disposition is made of all protests and complaints. If an intermediary receives a protest from an enrollee concerning an issue which is outside of the intermediary's area of responsibility, it should be forwarded to the Administration without delay and the enrollee advised of the referral. Where a complaint is received by the intermediary which encompasses more than one issue, some of which are outside of the intermediary's area of responsibility, the complaint should be referred to the Administration for consideration of those aspects of the protest over which the intermediary has no jurisdiction. However,

the intermediary should proceed with the review of that portion of the protest which falls within the confines of its adjudicative duties, provided that a decision on such portion of the complaint is not dependent on the Administration's determination on the other issues. Where such dependency exists, the intermediary will defer its review pending the Administration's decision on the other issues.









## CHAPTER IX

### TRANSMITTAL AND MAINTENANCE OF CLAIMS RECORDS

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Transmittals to Social Security Administration

## 3801. PREPARING BILLS FOR BATCHING

All staples, paper clips, bands, or other types of fasteners should be removed from the designated copy of the billing form being forwarded to SSA.

Any case-supporting documents (Report of Eligibility, Utilization Review Notice, developmental material, worksheets, etc.) must be retained by the intermediary, with his copy of the billing form. Such material must be available to SSA for audit, survey, or study purposes, however, and thus must be retained in association with the intermediary's case file. (Under certain circumstances a copy of the Explanation of Accommodation Furnished must be forwarded to SSA. See §3809 below.)

## 3803. BATCHING BILLS

After claims are completed to payment, whether on an individual case basis, in provider groups, or on some other basis, a batching by types of bills will be made prior to shipment to SSA. Since a given provider's bills will generally fall automatically within a designated category, no extensive sorting or examination of the bills should be required. An intermediary may already have segregated the bills by type to facilitate processing and control within his organization, or may wish to do so to coordinate his control to a greater degree with that of SSA.

Separate the bills to be transmitted to SSA, by type of bills and service, in the following categories:

1. Inpatient Hospital Admission and Billing - Form SSA-1453
- \*2. Outpatient Hospital Billing (Part A) - Form SSA-1483
- \*3. Outpatient Hospital Billing (Part B) - Form SSA-1483
- \*(Note: Where both Part A and Part B services are included on Form SSA-1483, the appropriate copies of the form will be included in each batch.)
4. Home Health Report and Billing (Part A) - Form SSA-1487
5. Home Health Report and Billing (Part B) - Form SSA-1487
6. Inpatient Psychiatric or Tuberculosis Hospital Admission and Billing - Form SSA-1485

7. Christian Science Admission and Billing - Hospital and Extended Care - Form SSA-1486

8. Extended Care Admission and Billing - Form SSA-1478

9. Notice of Discharge (Exhausted Benefits) - Billing forms submitted for days after inpatient benefits are exhausted to update the utilization record. All types of billing forms may be forwarded in the same batch.

10. Non-Payment Bills - Bills on which no payment is made, e.g., charges are less than the deductible, are to be batched separately and by type of bill as above for payment bills. Do not include more than one type of bill in each non-payment batch.

Adjustment bills, i.e., bills which are being submitted to SSA for adjustment of earlier bills on which errors have been discovered by the intermediary, may be submitted in each of the above categories but must be filed at the beginning of each batch (see §3806 below).

Batch each type of bill in batches of up to 50 bills for transmittal to SSA. Although not more than 50 bills of one type will be included in any one batch, smaller numbers may be transmitted to meet timeliness requirements. However, if you are submitting a number of bills that are not multiples of 50, it is preferable to divide them in two equal batches rather than transmitting one full batch (50 items) and one very small batch. For example, if 60 bills of one type are to be transmitted for the day, divide the bills in two batches of 30 items each rather than in two batches of 50 and 10 items, respectively. Batches of 2 or 3 bills are not encouraged.

### 3805. TIMELINESS

Since a vital feature of the entire program is the timely recording of the utilization data as shown on the billing forms, batches of bills should be forwarded as often as possible, preferably daily. Those intermediaries handling a high volume of particular types of bills will be able to ship full batches regularly without experiencing difficulty in accumulating bills to comprise full batches.

Even where a low volume of a particular type of bill is handled, bills should not be retained on the expectation of additional bills to enlarge the batch; timely filing is more important than size of shipment even though very small batches (§3803 above) are not encouraged.

On the last day of the calendar month all outstanding batches should be transmitted to SSA. Bills for which reimbursement has been made



in the current calendar month should not be intermixed and transmitted in a batch with bills that will be paid in the next calendar month.

### 3806. TRANSMITTAL AND CONTROL OF BILLS

Forward each batch shipment to SSA under cover of a transmittal, Form SSA-1559 (see Exhibit 1). The SSA-1559 should be prepared in duplicate with the original accompanying the batch shipment to SSA and the duplicate retained as the intermediary's record of shipment. Enter the following information on the SSA-1559 in the appropriate spaces:

1. Intermediary identification number (as assigned by SSA).

NOTE: If an intermediary has more than one paying office capable of submitting bills directly to SSA, individual intermediary numbers must be established and assigned to each office by SSA before SSA will accept bills from other than the parent office. Bills submitted prior to the assignment of a number to the paying offices will be returned to the parent office.

2. Intermediary's name and address.

3. Batch number. A consecutively assigned 3-digit number beginning with 001 and running through 999, and then repeated. The number should be assigned consecutively regardless of the type of batch; i.e., not a separate series for each type of bill. If an intermediary has more than one paying office submitting bills directly to SSA, each individual office must maintain separate consecutive batch numbers for the bills they submit.

4. Date batched (enter the shipment date of the batch).

5. Type of bills included in the batch (enter the form number of the bills included in the batch). Also, in Outpatient Hospital Billing (Form SSA-1483) and Home Health Report and Billing (Form SSA-1487) batches, Part A and Part B batches should be so indicated by showing the form number followed by "A" or "B," as appropriate. For nonpayment batches show, "Nonpayment" as well as the billing form number. Batches of exhausted benefits billing forms will be designated "Notice of Discharge," with no form number indication.

6. Total number of bills included in the batch. This number should represent the total pieces of paper in the batch. For example, when adjustments are included in a batch, a copy of the originally submitted bill will be included with the adjustment bill.

These should be counted as two bills even though they are to be processed as credit and debit actions for the same account and to determine the total amount of reimbursement represented by the batch.

7. Total amount of reimbursement represented by the batch. Credit and debit adjustments should be processed as plus and minus money amounts when determining the total amount of reimbursement. For exhausted benefits or nonpayment billing form batches, enter "Notice of Discharge" or "Nonpayment" in this space.

SSA will utilize the consecutively assigned batch numbers as a control to ensure that all batch shipments are received, and will routinely confirm receipt of the batches on a periodic basis. SSA will return a copy of each batch transmittal, Form SSA-1559, to the intermediary indicating SSA received and processed the batch (also see §3812). Skipped batch numbers, unless explained on the transmittal accompanying the next shipment, will result in an inquiry to reconcile the omitted numbers. Likewise, duplicate batch numbers will result in an inquiry to reconcile the duplication. In these cases a new batch number will normally have to be assigned.

A batch number will also be utilized in the reconciliation of shipments with the letter-of-credit reporting procedure, and for reference purposes in any contact or correspondence regarding discrepancies in batch-balancing processes. A register or reference list of batch numbers (duplicate SSA-1559's) and related data should therefore be maintained by the intermediary.

#### 3808. PACKAGING AND MAILING OF BILLS

More than one batch of bills may be included in the same package for mailing purposes, but each batch must be separated, with an appropriate covering transmittal, form SSA-1559. All bills should be packaged securely so that mutilation or other damage to the bills during mailing will be kept to a minimum. All bills should be sent by Air Express (where applicable) to:

Social Security Administration  
Bureau of Data Processing and Accounts  
P.O. Box 26  
Baltimore, Maryland 21203

#### 3809. TRANSMITTAL OF EXPLANATION OF ACCOMMODATION FURNISHED (FORM SSA-1484)

Where the intermediary determines that assignment to ward accommodations was not at the patient's request or was not consistent with the purposes of the Social Security Act, he retains one copy of Form



SSA-1484 in his file and transmits the other to SSA. Use the transmittal, Form SSA-1559, to forward such forms separately to SSA. Do not show a batch number. Complete the intermediary identification items and enter "Form SSA-1484" in the type of bill space. No other entry is necessary on the transmittal form.

The transmittal may be included with a package of bills, or mailed separately to the address in §3808. If mailed separately use regular mail.

#### 3812. DISCREPANT BILLS IDENTIFIED BY SSA

Occasionally it may be necessary for SSA to return batches of bills, or individual bills, to the intermediary because of discrepancies in batch totals, or in particular items on the bill. To ensure that the individual bills are returned into the processing system to update the utilization records, any such cases will be identified by SSA. As a part of the normal confirmation of receipt process, (§ 3806 above), all bills, or batches, returned to the intermediary for reconciliation of discrepancies will be returned with a copy of the Form SSA-1559 which accompanied the batch to SSA. The SSA-1559 will be annotated to show those bills being returned to the intermediary and the previous transmittal totals will have been adjusted to show the number of items and the amount of reimbursement actually processed by SSA. If the entire batch requires return, the SSA-1559 will merely be noted to indicate the return of all bills included in the batch.

The intermediary should expedite resolution and rebatching of such cases and adjust his records accordingly. If an entire batch has been returned, a new batch number must be assigned to the batch before it is returned to SSA for processing. The individual reconciled bills may be included in the appropriate type of batch for return to SSA in the next regular shipment.

#### 3814. OTHER ACTIONS AND MATERIAL

In addition to bills removed from the processing system prior to the updating of the utilization records, certain bills may be returned to the intermediary after the completion of all SSA processing. Such bills could involve requests for development or investigation of some aspect of the bill or verification of certain data. SSA will clearly identify and distinguish each of these bills from those which must be re-entered into the processing system for updating purposes.

After the intermediary's action is completed, such bills should be returned to SSA as individual items and not included in a batch of regular bills. Although the material may be mailed in the same package with a shipment of regular bills, these bills should be clearly identified as not requiring processing. Generally, such bills should be returned by letter mail to the organizational component which requested the action.



3816. ADJUSTMENTS AND/OR CANCELLATIONS BY THE INTERMEDIARY  
Occasionally the intermediary may find that bills previously submitted, and completely processed through SSA's system, are incorrect. In these cases adjustment or cancellation of the previously submitted bill may be required. These corrections may be transmitted to SSA along with regular bills of the same type under one Advice of Transmittal, Form SSA-1559. However, all such corrections should be placed on top of the regular bills when assembling the batch for shipment.

A copy of the originally submitted bill, acceptable for filming purposes (see below), must be prepared and forwarded to SSA for each adjustment or cancellation action. In those cases requiring adjustment of previously submitted bills, the copy of the original bill must be printed with the words "CREDIT CANCEL" in large red letters, in the extreme upper right-hand corner of the bill. The corrected bill, which should accompany the cancellation, should be printed with the words "DEBIT ADJ." in large red letters, in the extreme upper right-hand corner of the bill. If a previous bill requires cancellation only, the copy of the original bill should be annotated in the extreme upper right-hand corner with the phrase "CANCEL ONLY."

Because all claims forms must be acceptable for microfilming by SSA, only copying machines which produce clear copies may be used in preparing copies of the original submitted bill. If the print is light or blurred by the copying process, a typed copy will be necessary.

Files Maintenance

## 3820. GENERAL PROVISIONS

Subject to the provisions of the Code of Federal Regulations, Title 41, the Social Security Administration has the responsibility for the development and implementation of standards and programs for the economical management of records under the health insurance program. Specifically, SSA is required to provide for effective controls over the creation of records, including the making of records containing adequate and proper documentation of the intermediary's administration and operations.

The claims records referred to in this chapter are designated as Government records comprising Government-issued standard forms and other supporting forms needed to document claims records. Such Government forms will be developed, issued, printed, and distributed by the Social Security Administration and will be maintained by the intermediary in accordance with instructions regarding retention, transfer, destruction, and other disposition of claims materials.

Effective controls over records creation must encompass all types of records at all levels of organization, central office, and field.

Each Part A intermediary is required to establish and maintain an active, continuing program for the economical and efficient management of the records maintained by the intermediary of claims transactions under the health insurance program.

## 3821. FILES PROGRAM OBJECTIVES

Intermediary programs shall, among other things, provide for:

1. Effective controls over the creation, the organization, maintenance and use, and disposition of all SSA health insurance claims records.
2. Cooperation with SSA in developing and applying standards, procedures, and techniques designed to improve the management of claim records, assure the maintenance and security of records of continuing value, and facilitate the segregation and disposal of all records of temporary value.

The objectives of files management are to organize intermediary files so that needed records can be found rapidly; complete records are ensured; the selection and retention of records of value are facilitated; and the disposition of noncurrent records is accomplished with maximum economy in personnel, equipment, and supplies.

3821.1 Creation of Files for Records.--Adequate records management controls over the creation of intermediary files shall be instituted to insure that important policies and decisions are adequately recorded; that routine operational paper work is kept to a minimum; and that the accumulation of unnecessary files is prevented. Effective techniques to be applied in this area include the application of systems for the control of correspondence and forms; the minimizing of duplicate files; and the disposal without filing of transitory material that has no value for record purposes.

3821.2 Files Defined.--A file is basically a paper or folder of papers, but the term is used to denote papers, photographs, photographic copies, magnetic tapes, or other recorded information regardless of physical form or characteristics, accumulated or maintained in filing equipment, boxes, or on shelves, and occupying office or storage space. Stocks of publications and blank forms are excluded.

Specifically the materials affected relate to transactions involved in determinations of eligibility of health insurance beneficiaries, the coordination and communications relative to the processing and payment of claims for services rendered to health insurance beneficiary patients by a health service organization.

3821.3 Files Program Requirements.--Each intermediary, in providing controls over the creation of records, is expected to establish an appropriate program for the management of intermediary files. The program will:

A. Establish and implement standards and procedures issued by SSA for:

1. classifying, indexing, and filing records;
2. providing reference services to filed records;
3. locating active files to facilitate use of the records;
4. reviewing the program periodically to determine the adequacy of the system and its effectiveness in meeting requests.

B. Insure that the standards, guides, and instructions developed for the files management program should be readily available to all employees concerned with the files operations. In addition, pertinent information for users of files and reference services should be given the widest possible dissemination.



### 3822. FILES PROGRAM IMPLEMENTATION

The following actions are generally basic to a files management program:

#### A. Standardize classification and filing schemes to:

1. achieve maximum uniformity and ease in maintaining and using program records;
2. facilitate disposal of records in accordance with applicable records disposal schedules;
3. facilitate possible later consolidation of identical type files presently maintained at different locations.

B. Formally authorize official file locations. Prohibit the maintenance of files at other than authorized locations.

C. Standardize reference service procedures to facilitate the finding, charge-out, and refiling of records.

D. File accumulations of papers received at file locations on a daily basis.

E. Audit periodically a representative sample of the files for duplications, misclassification, or misfiles.

### 3823. ORGANIZATION, MAINTENANCE AND USE OF FILES

Provision shall be made for the continued analysis and improvement of such matters as record classification and indexing systems, the use of filing equipment and supplies, the reproduction and transportation of records, and to assure that records are maintained economically and efficiently, and in such a manner that their maximum usefulness is attained.

The files established by the intermediary, and all records and procedures documenting the intermediary programs for controlling the creation, maintenance, and use of current records; for the selective retention of records of continuing value; and for the disposal of noncurrent records will be available for periodic review by the Social Security Administration.

### 3825. DESCRIPTION OF FILES MAINTAINED

The methods of maintaining and clearing temporary pending files and closed bill files will vary with the intermediary. These will depend on the filing and control methods established by the provider, health insurance claim number, name, or other sequence

to record requests from providers; to furnish replies; to check on overdue cases; to control cases for completion of processing and payment; to control cases requiring some type of investigation or additional documentation; to retain completed cases for history or other reference; to maintain for audits; and to schedule for transfer to other storage areas.

Other variances in the intermediary's methods of filing will depend on computer or clerical practices; workload volume; review initiated at time of notice of admission, at time of start of care, or at time of receipt of billing form, and other considerations.

Regardless of the practices generally followed by the intermediary, the SSA procedures and workflow may require certain adaptations to effectively coordinate the workflow and interaction between the interests of health insurance beneficiaries, providers, intermediaries and the central SSA recordkeeping and processing operations.

The following descriptions and workflow relate to files maintenance operations according to the pattern of the individual intermediary.

3825.1 File Pending Receipt of the Reply to the Notice of Admission or Start of Care.--A pending file of Notice of Admission forms, Start of Care Notices, or equivalent data should be maintained by the intermediary to await receipt of the Reply to the Notice of Admission or Start of Care from SSA.

The Reply to the Notice of Admission or the Start of Care will contain the patient's health insurance claim number and the provider number. The pending file should therefore be established in a sequence to facilitate association of inquiries with replies and to identify inquiries requiring followup requests.

3825.2 File Pending Receipt of the Bill for Services.--After the Reply to the Notice of Admission or the Start of Care has been received by the intermediary, and the reply forwarded to the provider initiating the transactions, the materials included in the File Pending Receipt of the Reply to the Notice of Admission or Start of Care may be associated or transferred to a Control File Pending Receipt of the Bill for Services, depending on the procedures established by the intermediary.

NOTE: In some cases, a small additional control pending file may need to be established where the analysis of the SSA reply to the Notice of Admission or the Start of Care does not permit immediate forwarding of the reply data to the provider. This may occur in cases where the intermediary



requires further investigation (e.g., contact with another intermediary, hospital, or extended care facility may be required where the HI beneficiary was an inpatient in the last 60 days).

This file should generally be maintained in Health Insurance Claim Number sequence, provider and date sequence, or other sequence designed to permit ready reference and to identify overdue open items requiring followup status requests to the provider.

Upon receipt of the bill for services, the material contained in the File Pending Receipt of the Bill for Services, may be transferred to bill-review or case processing status according to the internal procedures established by that intermediary for processing health insurance claims.

3825.3 File Pending Receipt of Reply to Development Requests.--In selected cases, Part A intermediaries will have need to initiate development to reconcile incomplete, inconsistent or inaccurate entries on bills for services. Pending the receipt of the reply to any such development requests, the intermediary will hold the claims material in a Current Bill Review Pending File. This file will generally be maintained in Health Insurance Claim Number or other acceptable sequence.

3825.4 File Pending Posting of the Claims Data into the Records of the Social Security Administration.--Processed bills for service will be batched and forwarded by the intermediary to the Social Security Administration for posting into the central SSA records.

The intermediary copy of the processed bill and any accompanying materials should be maintained by the intermediary for a period of one month in a closed temporary file to facilitate current reference and such reconciliation operations as may be required.

This file will ordinarily be maintained in batch number sequence corresponding to the batches forwarded to SSA for posting to EDP records. (This file may be maintained in some other sequence provided the intermediary's system will permit speedy location and association of claims-related materials.)

3825.5 Permanent Record File.--After all action as to reimbursement and posting to SSA records is completed, and the one-month period set out in § 3825.4 above has passed, the bills and related materials will be retired to a permanent record file. This file will generally be maintained in yearly files in Transmittal Batch Number, date, HI claim number, or other acceptable sequence.



This file will be used to conduct audits; to serve as a reference file to refer to specific bills in order to obtain detailed information on health insurance beneficiaries; to answer status requests, complaints, or other correspondence relative to a particular bill; and to accommodate other needs which may be presented in the successful administration of the health insurance program.

3825.6 List of Part A Intermediary Claims Materials.--

- (1) Notice of Admission.
- (2) Reply to Notice of Admission (form or wire copy).
- (3) Notice of Start of Care.
- (4) Reply to Notice of Start of Care.
- (5) Inpatient hospital bills (Form SSA-1453).
- (6) Inpatient tuberculosis and psychiatric hospital bills (Form SSA-1485).
- (7) Inpatient extended care facility bills.
- (8) Part A home health agency bills (Form SSA-1487).
- (9) Part B home health agency bills (Form SSA-1487).
- (10) Inpatient emergency hospital bills (Form SSA-1453).
- (11) Outpatient hospital bills--Part A (Form SSA-1483).
- (12) Outpatient hospital bills--Part B (Form SSA-1483).
- (13) Outpatient emergency hospital bills (Form SSA-1483).
- (14) Payment vouchers.
- (15) Medical or hospital record documentation resulting from investigation or certification requirements.
- (16) Material from nonparticipating hospitals or extended care facilities resulting from development of alleged prior stays within the last 60 days.
- (17) Part B status inquiry.
- (18) Reply to Part B status inquiry.
- (19) Any other claims-related materials peculiar to specific transactions under the program, necessary for reasons of documentation.

3828. RETENTION OF CLAIMS FILES MATERIALS

Provision shall be made to insure that records of continuing value are preserved but that records no longer of current use to the program are promptly disposed of or retired.

3828.1 Standard Retention (At Least Six Months).--Claims materials and other adequate records concerning the use of funds under both Part A and Part B shall ordinarily be maintained by the Part A intermediary until the expiration of not less than 6 months after the date of initial payment, after which the records will be transferred to a Federal Records Center. Bills will be forwarded from the intermediary's storage area to the Federal Records Center in January and August of each year.

The dispatch in January will consist of those bills paid in the 6-month period, January through June of the previous year. The dispatch in August will consist of bills paid in the 6-month period, July through December of the previous year. The first transfer is scheduled for August 1967.

NOTE: After the bill-review process is completed, no further changes, deletions, strike-overs, or other entries should be made on the forms or claims materials except as provided by SSA instructions.

### 3828.2 Modifications of the Standard Retention Period.--

A. Yearly or Bi-yearly Period.--Approval may be given for those intermediaries with a small claims volume or those having both Part A (provider services) and Part B (physician services) responsibilities to combine records rather than maintain them separately by batch number; for example, health insurance claim number sequence by calendar year or by 2-year calendar year period. Such intermediaries would be of the type where clerical operations require case examination of prior history file for detection of duplicate claims; incurred date sequence; bill-review for coverage patterns and other consistency checks. Variations in retention period could depend on volume, degree of reference, etc.

The period of retention and transfer here could be the same as the standard, or after specific approval on an individual intermediary basis, by a 1-or-2-year health insurance claim number sequence, permitting transfer every year or second year, as in the following examples:

#### Example 1:

7/1/66 - 12/31/66    Segment 1:  
1/1/67 - 12/31/67    Segment 2:  
1/1/68 - 12/31/68    Segment 3: at 1/1/68, transfer Segment #1.  
1/1/69 - 12/31/69    Segment 4: at 1/1/69, transfer Segment #2.  
Each year, begin a new active file segment.

#### Example 2:

7/1/66 - 6/30/67    Segment 1:  
7/1/67 - 6/30/68    Segment 2: at 1/1/68, transfer Segment #1.  
7/1/68 - 6/30/69    Segment 3: at 1/1/69, transfer Segment #2.

Example 3:

7/1/66 - 6/30/68 Segment #1:  
 7/1/68 - 6/30/70 Segment #2: at 1/1/69, transfer Segment #1.  
 7/1/70 - 6/30/72 Segment #3: at 1/1/71, transfer Segment #2.

B. Bi-Monthly Period.--Approval may be given for those intermediaries who have been authorized to microfilm claims records (on the basis of individual submittals including documented cost justifications) to retain original source documents for 2 months before transfer to the Federal Records Center. Each month a transfer of a 2-month matured segment will be made.

Example:

7/1/66 Records--transfer 9/1/66  
 8/1/66 Records--transfer 10/1/66

Other modifications of the retention period may be approved by SSA after detailed consideration is given to the experience with retained and recalled records; the type of references to individual records; the degree and frequency of any such reference; and audits, studies, and other usages having a bearing on periods of retention.

3829. DOCUMENTATION OF FILE REFERENCES AND REQUESTS FOR MODIFICATION Under all retention systems (monthly intervals for microfilmers; 6-month standard intervals; or 1-or-2-year intervals for smaller volume clerical processors), the intermediaries should document by monthly tally, the number of records requiring post-bill review reference. Show the reason for reference; number of references, and length of time after bill is processed. Exclude from this tabulation all references arising from current processing to reconcile batches.

Example--Tabulate:	Reason	Number	Months after Bill Review
	SSA Request (indiv.)	--	1
	" " "	--	2
	" " "	--	3 etc.
	SSA Request (study)	--	
	HI Beneficiary Request	--	1
	" " "	--	2
	" " "	--	3 etc.
	DHEW AUDIT	--	1
	" " "	--	2
	" " "	--	3 etc.



On the basis of such data, submittals may be initiated to obtain approval for a modified period of retention. Such a request should be sent to the following address:

Social Security Administration  
Bureau of Health Insurance  
Division of Methods and Procedures  
Room 4Q6 Operations Building  
Baltimore, Maryland 21235

Evaluation of these tabulations, together with study and audit findings and evaluations by SSA, will be used to develop later procedures to provide for earlier transfer or selected destruction of materials, as warranted.

### 3830. TRANSFER OF CLAIMS FILE MATERIALS

Bills and related claims materials may be transferred to Federal Records Centers after the period of retention set forth in § 3828. No records shall be transferred from one intermediary to another, to other storage space, or to the Federal Records Center except pursuant to written instructions issued by the Social Security Administration.

Detailed instructions will be issued to the intermediary before the first scheduled transfer to the Federal Records Center. These instructions will concern the methods of transferring claims materials to Federal Records Centers and the method of recalling specific claims materials, if necessary, from Federal Records Centers. The instructions will include the locations of the Federal Records Centers to which the individual intermediaries will transfer records.

### 3850. EXHIBITS

Exhibit No. 1. Advice of Transmittal for Hospital Insurance Bills (Form SSA-1559).



Form Approved.  
Budget Bureau No. 72-R744



## ADVICE OF TRANSMITTAL FOR HOSPITAL INSURANCE BILLS

DELIVER TO:

Social Security Administration  
Bureau of Data Processing and Accounts  
P.O. Box 26  
Baltimore, Maryland 21203

## INTERMEDIARY IDENTIFICATION

NUMBER,

NAME AND ADDRESS

## HI BILLS INCLUDED IN THIS TRANSMITTAL

BATCH NUMBER	DATE BATCHED	TYPE OF BILLS (form number)
TOTAL NUMBER OF BILLS IN BATCH		TOTAL REIMBURSEMENT AMOUNT

## HI BILLS DELETED FOR RETURN TO INTERMEDIARY

[illegible]

## SSA PROCESSING TOTALS

	NUMBER OF BILLS	REIMBURSEMENT AMOUNT	DATE RETURNED
Received by SSA			
Deleted by SSA			
Processed by SSA			

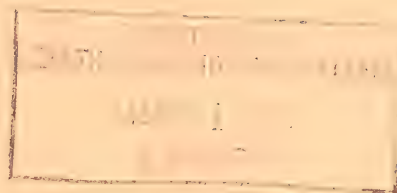












# HEALTH INSURANCE FOR THE AGED

## HIM - 13 PART A INTERMEDIARY MANUAL





DEPARTMENT OF HEALTH, EDUCATION, AND WELFARE  
SOCIAL SECURITY ADMINISTRATION  
BALTIMORE, MARYLAND 21235

August 15, 1966

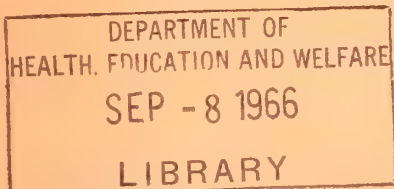
PART A INTERMEDIARY MANUAL

REVISION TRANSMITTAL NO. 1

<u>New Material</u>	<u>Page No.</u>	<u>Replaced Pages</u>
Check Sheet for Revision Transmittals		
Table of Contents	1 - 11	1 - 11
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This Revision Transmittal manualizes the Part A intermediary statistics and reports material, including instructions on preparation of the monthly Intermediary Workload Report, which were in Intermediary Letters Nos. 31 and 48. There are no substantive changes, other than a change in the address from which supplies of report forms may be obtained (§ 3860). Intermediary Letters Nos. 31 and 48 may be discarded by both Part A and Part B intermediaries.

We have also included a check sheet for use of manual holders in recording receipt of revision transmittals.



Arthur E. Hess, Director  
Bureau of Health Insurance





# 8-66 CHECK SHEET OF PART A INTERMEDIARY MANUAL REVISION TRANSMITTALS

This Check Sheet should be placed at the front of the Manual immediately after the Foreword, to provide a record of Manual revisions received. Part A Intermediary Manual revisions will be issued under cover of numbered "Revision Transmittals."

Trans. No.	Date	Trans. No.	Date	Trans. No.	Date	Trans. No.	Date	Trans. No.	Date
1.	_____	21.	_____	41.	_____	61.	_____	81.	_____
2.	_____	22.	_____	42.	_____	62.	_____	82.	_____
3.	_____	23.	_____	43.	_____	63.	_____	83.	_____
4.	_____	24.	_____	44.	_____	64.	_____	84.	_____
5.	_____	25.	_____	45.	_____	65.	_____	85.	_____
6.	_____	26.	_____	46.	_____	66.	_____	86.	_____
7.	_____	27.	_____	47.	_____	67.	_____	87.	_____
8.	_____	28.	_____	48.	_____	68.	_____	88.	_____
9.	_____	29.	_____	49.	_____	69.	_____	89.	_____
10.	_____	30.	_____	50.	_____	70.	_____	90.	_____
11.	_____	31.	_____	51.	_____	71.	_____	91.	_____
12.	_____	32.	_____	52.	_____	72.	_____	92.	_____
13.	_____	33.	_____	53.	_____	73.	_____	93.	_____
14.	_____	34.	_____	54.	_____	74.	_____	94.	_____
15.	_____	35.	_____	55.	_____	75.	_____	95.	_____
16.	_____	36.	_____	56.	_____	76.	_____	96.	_____
17.	_____	37.	_____	57.	_____	77.	_____	97.	_____
18.	_____	38.	_____	58.	_____	78.	_____	98.	_____
19.	_____	39.	_____	59.	_____	79.	_____	99.	_____
20.	_____	40.	_____	60.	_____	80.	_____	100.	_____

Trans. No.	Date	Trans. No.	Date	Trans. No.	Date	Trans. No.	Date	Trans. No.	Date
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102.	_____	127.	_____	152.	_____	177.	_____	202.	_____
103.	_____	128.	_____	153.	_____	178.	_____	203.	_____
104.	_____	129.	_____	154.	_____	179.	_____	204.	_____
105.	_____	130.	_____	155.	_____	180.	_____	205.	_____
106.	_____	131.	_____	156.	_____	181.	_____	206.	_____
107.	_____	132.	_____	157.	_____	182.	_____	207.	_____
108.	_____	133.	_____	158.	_____	183.	_____	208.	_____
109.	_____	134.	_____	159.	_____	184.	_____	209.	_____
110.	_____	135.	_____	160.	_____	185.	_____	210.	_____
111.	_____	136.	_____	161.	_____	186.	_____	211.	_____
112.	_____	137.	_____	162.	_____	187.	_____	212.	_____
113.	_____	138.	_____	163.	_____	188.	_____	213.	_____
114.	_____	139.	_____	164.	_____	189.	_____	214.	_____
115.	_____	140.	_____	165.	_____	190.	_____	215.	_____
116.	_____	141.	_____	166.	_____	191.	_____	216.	_____
117.	_____	142.	_____	167.	_____	192.	_____	217.	_____
118.	_____	143.	_____	168.	_____	193.	_____	218.	_____
119.	_____	144.	_____	169.	_____	194.	_____	219.	_____
120.	_____	145.	_____	170.	_____	195.	_____	220.	_____
121.	_____	146.	_____	171.	_____	196.	_____	221.	_____
122.	_____	147.	_____	172.	_____	197.	_____	222.	_____
123.	_____	148.	_____	173.	_____	198.	_____	223.	_____
124.	_____	149.	_____	174.	_____	199.	_____	224.	_____
125.	_____	150.	_____	175.	_____	200.	_____	225.	_____



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Statistics and Reports

## 3851. OBJECTIVES OF STATISTICAL PROGRAM

The Health Insurance Program for the Aged will have a great impact on the financing of medical care services in this country, on the number and kinds of health care facilities and personnel, and on the amount and kinds of health services utilized by the aged as well as by other age groups. At the same time, the program will offer a means for obtaining detailed, systematic, and continuous statistics about the amount, kind, and cost of health care services used by the aged as a by-product of benefit payment operations.

The need for statistics about the operation of the program and its impact are expressly recognized in Public Law 89-97, "The Health Insurance for the Aged Act." Section 1875(b) expressly directs that,

"The Secretary shall make a continuing study of the operations and administration of the insurance programs under parts A and B and shall transmit to the Congress annually a report concerning the operation of such programs."

The statistical program has, therefore, been designed primarily to provide recurrent basic data on program operations and administration.

The Congress, the Social Security Administration, the medical community, and many other groups will be concerned with assessing program operations and administration in terms of the goals of the program to protect the aged person against the costs of hospitalization and illness and to provide quality hospital and medical care in the most efficient and economical manner. In this connection, an important focus of the statistical program will be to provide data necessary to analyze and compare operations of intermediaries with respect to the effective and efficient operation of the program.

## 3853. HOW STATISTICS WILL BE COLLECTED

All basic, recurrent program statistics will be collected and compiled centrally by the Social Security Administration. Intermediaries will not be required nor expected to tabulate and prepare any routine statistical reports.

Program statistics--data needed to evaluate the program and assess its performance--will be derived as a by-product of the claims billing and payment process, and of the State agency process of certifying providers (hospitals, nursing homes, et al) for

participation in the program. Other information required will be derived from accounting and benefit payment records maintained by SSA as part of its normal operations.

More specifically, administration of the health insurance program will require establishment of a master tape record that identifies every aged person who is eligible for health insurance benefits. The master record will also contain information about utilization of services under the program to meet administrative and operating needs.

Each episode of hospitalization, each use of extended care facilities, and each use of home health services by each individual beneficiary will be recorded in the master records. The information for the master record will be derived from admission notices and billing forms that will be submitted by participating medical care facilities through their intermediaries every time a program beneficiary is admitted to or discharged from a participating facility.

Similarly, every provider that wishes to participate in the health insurance program will need to file an application for this purpose. These application forms will also contain information about each provider that will be used for statistical purposes (size, ownership, range of services available, accreditation status, medical school affiliation, approved training programs, etc.). This information will also be recorded in SSA records and will be updated periodically as States recertify providers.

Thus, all recurrent program statistics will be derived by SSA as a by-product of forms and records that are established and maintained for administrative purposes. Occasionally, needs will arise for statistics and data that are not available as a by-product of the claims and billing process. Intermediaries may, therefore, be called upon as the need arises to assist the SSA in collecting required data and in conducting required studies.

Intermediaries will be required to prepare only one repetitive statistical report--the Intermediary Workload Report. This will be a summary report, prepared and submitted monthly, which will contain gross figures on intermediary workloads, including counts of bills received, processed, and pending.

### 3855. ACCURACY AND COMPLETENESS OF BILLING FORMS

Copies of billing forms received by intermediaries from hospitals, extended care facilities, and home health agencies will be sent to SSA in Baltimore for posting to master records and will be the source of utilization statistics. Accordingly, copies of all forms



sent to SSA should be completed in full and clearly legible. Where individual forms must be reproduced, high quality reproduction is essential.

Intermediaries should assure that providers with whom they deal process and complete admission and billing forms and related forms in accordance with instructions given them by SSA. It is especially important that providers of service complete billing forms accurately and in the detail called for by instructions. Diagnoses and surgical procedures should be specified in detail using acceptable terminology such as Current Medical Terminology, Standard Nomenclature of Diseases and Operations, The American Psychiatric Association's Diagnostic and Statistical Manual, etc.

When forms furnished by providers of service are not complete, or contain erroneous information, intermediaries should contact providers to obtain missing and/or correct information. Where corrections are made on the form, they should be clear and legible. Hospitals will report outpatient services given under the Hospital Insurance Plan (Part A) or the Supplementary Medical Insurance Plan (Part B) on the same billing form--the Outpatient Hospital Billing (Form SSA-1483). Where both Part A and Part B services are reported on the same billing form, intermediaries should make sure that services provided under the supplementary medical insurance program are clearly and correctly classified and identified.

#### 3857. PERIODIC REPORT OF CASES REVIEWED BY PROVIDER UTILIZATION REVIEW COMMITTEES

Intermediaries will be greatly involved, along with State agencies, in implementing the utilization review provisions of the Health Insurance for the Aged Program. They will have primary responsibility for continuously assisting providers in the application of utilization safeguards.

In establishing their eligibility to participate in the Health Insurance Program, providers will be asked to furnish descriptions of their utilization review plans (actual or proposed) to the State agencies. As part of their responsibility in the area of utilization practices, intermediaries will be reviewing the ongoing operation of the U.R. plans previously submitted to the State agencies by the providers with whom they deal to determine whether or not the plans are actually operating as initially described. This review will undoubtedly involve collection of data about the cases reviewed by individual U.R. committees. We would like intermediaries to share with us the information they obtain on cases reviewed by individual U.R. committees.

3859. STATISTICAL INFORMATION TO BE PROVIDED TO INTERMEDIARIES  
BY SSA

Copies of all statistical reports, pertaining to the hospital insurance program published by SSA will be made available routinely to intermediaries. In addition, SSA will make available to intermediaries some basic statistics, relating to the providers of service with whom they deal, to be used in carrying out their function to assist providers in the application of utilization safeguards. The data will enable intermediaries to compare, using several basic measures of utilization, the experience of individual providers (with whom they deal) with each other and with providers with comparable characteristics dealing with other intermediaries. Data will be furnished on a current basis. The data will show such things as--

1. Length of stay for beneficiaries discharged during the report period related to certain characteristics of beneficiaries-- e.g., primary diagnosis, presence of complicating conditions, primary surgical procedures, age, sex, etc.

2. Length of stay and characteristics of beneficiaries discharged during the report period related to kind of ancillary services used.

Provision will be made for consultation with individual intermediaries to assure that data meeting their needs are compiled and tabulated.

Situations may arise where intermediaries will need to compile statistics or conduct studies for administrative purposes, where the data needed are not available from SSA. In such instances, it may be necessary for intermediaries to compile and tabulate the required data themselves. When the costs of obtaining the required data are expected to exceed \$10,000 intermediaries should request written approval from SSA in advance. Requests for prior approval should describe the data to be collected, how the data will be collected, why the data are needed, and the estimated cost involved.

3860. MONTHLY STATISTICAL REPORT ON STATUS OF INTERMEDIARY  
WORKLOADS (INTERMEDIARY WORKLOAD REPORT (FORM SSA-1566))

Each intermediary will prepare and submit to the Social Security Administration a short report each month showing the status of its workloads under the Health Insurance Program. A separate report is to be completed for each intermediary office that has been assigned an intermediary number. However, when an intermediary's area covers more than one State a separate report should be prepared for each State.



The purpose of the report is to provide information, quickly and in summary fashion, on the number of bills received and processed each month, and the number pending at the end of each month. This information is needed for administrative and operating purposes, including the development of intermediary budgets. The report will also measure the progress of intermediaries in paying claims for reimbursement for hospital and related posthospital services under the Health Insurance Program.

The report will be submitted on Form SSA-1566 (Intermediary Workload Report). Forms may be obtained by writing directly to:

Bureau of Health Insurance  
Distribution Liaison Officer  
Social Security Administration  
Baltimore, Maryland 21235

Reports will be prepared monthly in accordance with the instructions that follow.

3860.1 Purpose and Scope.--Form SSA-1566, Intermediary Workload Report for the Health Insurance Program is the principal source for summary information on the current status of operations of intermediaries. The information supplied will provide a current profile of the overall operating situation for intermediaries.

3860.2 Due Date.--Form SSA-1566 is due in Baltimore as soon as possible after the end of the reporting period, but no later than the tenth of the succeeding month. Airmail should be used by intermediaries west of the Mississippi River, or in any instance which would expedite receipt of the report.

3860.3 Number of Copies.--The intermediary will submit (2) copies of the Workload Report each month. Send both copies of the report to: Social Security Administration, Office of Research & Statistics, Attention: Health Insurance Statistics Branch, P.O. Box 1433, Baltimore, Maryland 21203.

3860.4 Heading.--Enter the name and code number of the intermediary reporting.

3860.5 Reporting Period.--Prepare the Intermediary Workload Report for each calendar month.





# HEALTH INSURANCE FOR THE AGED PROGRAM INTERMEDIARY WORKLOAD REPORT

Form Approved.  
Budget Bureau No. 72-R737

	NAME OF INTERMEDIARY	CODE	REPORTING PERIOD (Month and Year)		
			HOSPITAL	HOME HEALTH SERVICES	
				INPATIENT	OUTPATIENT
	TOTAL	PART A	PART B	PART A	PART B
<b>BILL PROCESSING OPERATION</b>					
1. OPENING PENDING	a. Bills pending end of last month				
	b. Adjustments in pending (+ or -)				
	c. Total Opening Pending				
2. RECEIPTS	a. Bills received this month				
	b. Bills returned for additional information (-)				
	c. Bills rejected (-)				
	d. Net Receipts				
3. PROCESSED	a. Bill processed for payment				
	(1) Bills processed (No Investigation Required)				
	(2) Bills processed (Investigation Required)				
	b. No payment bills processed (forward to SSA)				
	c. Adjustment bills processed				
4. CLOSING PENDING	d. Total Processed				
	a. Pending (Received this month)				
	b. Pending (Received prior month)				
5. BILL INVESTIGATIONS	c. Total Pending				
	Bills requiring investigation (Not returned to claimant)				
6. REASONS FOR INVEST. & RETURNS (Items 2b & 5)	a. Incomplete items				
	b. Incorrect computations				
	c. Inconsistent Diag.-Serv.-Proc.				
	d. Other				
7. RETURNS FROM SSA	a. Received				
	b. Cleared				
	c. Pending				
8. REMARKS					
		SIGNATURE		DATE	
		TITLE			

3860.6 Type of Bill.--Bills for reimbursement for covered services under the Health Insurance Program will be received from providers of: (a) inpatient hospital services; (b) hospital outpatient diagnostic and therapeutic services--for Part A and Part B services; (c) extended care services; and (d) home health services--for Part A and Part B services. Bills will be received either upon discharge or completion of care, or, in cases of extended treatment, on a periodic basis (i.e., monthly, quarterly, etc.). Count each bill, whether final or intermediate, as a single bill for monthly reporting purposes, in the appropriate column. If the same bill contains Part A and Part B services for outpatient hospital services, record as two bills. These can easily be identified since two distinctly colored forms will be submitted in such a situation.

### 3862. COMPLETING ITEMS ON FORM SSA-1566

#### Item 1. Opening Pending

- a. Bills pending end of last month--Self-explanatory.
- b. Adjustment in pending--If error is found in previous end of month's pending (as a result of inventories, duplicate bills, etc.) the adjustment should be entered here. Entry should be preceded by a plus or minus sign, as appropriate. Explain reason for adjustment in remarks section.
- c. Total opening pending--Enter here the result of the above adjustment.

#### Item 2. Receipts

- a. Bills received this month--Enter here all bills received during the month, including those that have been previously handled, but not including bills returned by SSA. Include here all bills regardless of whether payment will be made. Also enter here bills which require an adjustment of an earlier bill on which errors have been discovered by the intermediary. This count should be made at the point where bills are normally controlled before going to the claims examiner.
- b. Bills returned for additional information--Report here the number of bills received that fiscal intermediary returns to provider of services or other purveyor of medical service because the form is incorrectly completed, incorrect computation, etc.

- c. Bills rejected--Report here the number of bills received that are rejected because bill is clearly for services not covered under the law or is from a nonparticipating provider not eligible for payment under the HIB program. Do not count here bills not meeting the deductible.
- d. Net receipts--This is the result of subtracting lines 2b and 2c from 2a.

Item 3. Processed

- a. Bills processed for payment--Report here the total number of bills that were processed during the month to completion for which payment was or will be made. The number shown here will be the sum of the numbers in lines 3a(1) and 3a(2) of the report.
  - a.(1) Report here the number of bills processed to payment during the month where no investigation or no additional information was required (i.e., bill was not returned to the provider for correction nor was contact made with the provider or other outside source in any manner for additional information regarding the bill). Include here bills where the amount of reimbursement claimed by a provider is adjusted if the adjustment is made without investigation or without contacting the provider.
  - a.(2) Report here the number of bills processed to payment during the month where additional information or investigation was required before reimbursement could be made.
- b. No payment bills--Report here the number of bills processed during the month but no reimbursement is made because the deductible is not met or coverage was exhausted. This item differs from item 2c in that services fall within scope of law but no payment is made because of limitations placed on service.
- c. Adjusted bills--Report here bills which are being submitted to SSA for adjustment of an earlier bill on which errors have been discovered by the intermediary. Do not count here bills that were returned by SSA.
- d. Total processed--Sum of a, b, and c.



Item 4. Closing Pending--Report here the total bills received but not processed to final action by the end of the month. Show separately the number of bills still pending that were received in the current (reporting) month and the number that were received in the prior month. Closing pending should be arithmetically equal to the total opening pending (line 1c) plus net receipts (line 2d) less total processed (line 3c).

Item 5. Bill Investigations--(Not returned to provider)--Enter here the number of bills that were investigated during the month but where the bill itself was not returned to the provider. Count only the number of bills on which an investigation is initiated during the month, not the number of contacts made.

Item 6. Reasons for Investigations--Count here all reasons for which a bill was investigated, whether bill was returned to provider or not. If a bill is investigated for more than one reason, record each reason under the appropriate item as shown on the report form.

Item 7. Returns from SSA--

- a. Received--Record here the total number of bills returned from SSA for resolution of some question or inconsistency.

Do not count bills returned from SSA in item 2a.

- b. Cleared--Enter here the number of bills returned from SSA that were reprocessed and resubmitted to SSA.

- c. Pending--Enter here the number of such bills received but not yet resubmitted to SSA.

Item 8. Remarks--Self-explanatory.

Signature--Space for Signature of Official responsible for report.

Title--Space for Title of Official responsible for report.

Date--Date report is completed.





DEPARTMENT OF HEALTH, EDUCATION, AND WELFARE  
SOCIAL SECURITY ADMINISTRATION  
BALTIMORE, MARYLAND 21235

September 7, 1966

PART A INTERMEDIARY MANUAL

HIM-13 - Part 3

REVISION TRANSMITTAL NO. 2

<u>New Material</u>	<u>Page No.</u>	<u>Replaced Pages</u>
Sec. 3701 - 3713	243-244	243-244
Sec. 3801 - 3816	271-276.1	271-276

Section 3710 has been redrafted to specify that in corrected bill situations intermediaries should transmit to SSA only one copy of the bill labeled "DEBIT-ADJUST" along with the "CREDIT-CANCEL" copy. The other "DEBIT-ADJUST" copy should be retained by intermediaries for their own records. This has been done to avoid any misunderstanding about the disposition of the three copies of the bill prepared by providers in this situation.

Section 3801 has been revised to provide for use of staples when more than one Form SSA-1483 (Outpatient Hospital Billing) is needed to list all the services covered by a single bill.

Section 3803 revises batching categories 9 and 10, and adds category 11. Category 9, formerly described as "Notice of Discharge (Exhausted Benefits)," is changed to "Nonpayment Bills" and includes bills on which no payments can be made because benefits are exhausted, workmen's compensation paid the entire bill, or services are not covered. Category 10, formerly described as "Nonpayment Bills," is changed to "Unmet Deductible Bills"; only bills on which no payment is made because charges are less than the deductible are to be batched in this category. Category 11 is an additional category which provides for separate batching of adjustment and/or cancellation bills by type of bill. The "Note:" under categories 2 and 3 has been expanded to explain that Part B copies of the Outpatient Hospital Billing (Form SSA-1483) should not be submitted unless there are medical plan charges or Item 21D shows an amount payable.

Section 3806.--Items 5 and 6 have been revised. Item 5 has been updated to reflect the changes resulting from the revision of bill categories



in section 3803. Item 6 indicates that where it is necessary to include more than one Form SSA-1483 for a single billing, the stapled forms will be considered one bill.

Additional guidelines are included for making a final check to ensure that each batch is properly assembled. Also, the statement that SSA will routinely confirm receipt of batches on a periodic basis has been deleted to avoid the impression that something other than a copy of the Form SSA-1559 will be transmitted to intermediaries as confirmation of receipt.

Section 3816 has been changed to explain the necessity for submitting an exact duplicate of the original bill in adjustment submittals.

A handwritten signature in dark ink, appearing to read "Arthur E. Hess", is positioned above the typed name.

Arthur E. Hess, Director  
Bureau of Health Insurance

## 3701. NOTICE OF PAYMENT

Under the health insurance law, payments to providers must be made not less often than monthly. A notice of payment is to be sent to the provider when payment is made. The intermediary should also notify the provider of the patient's verified liability where pertinent. This is especially important where the provider chooses to wait for Part B outpatient and home health benefits to be paid before collecting any amount of the deductible and coinsurance from the patient. The provider will not know the exact status of the patient's deductible unless the patient presents a utilization notice showing that the deductible was met in the year. If the provider waits for the benefit payment before collecting from the patient, there would be fewer erroneous bill collections which would have to be refunded. Although the method and format of the notice is left up to the intermediary, the verification of the patient's liability should be included on the voucher which explains the amount of the benefit check to the provider.

## 3702. BENEFIT CHECKS

The payment checks will contain the legend:

"For Health Insurance--Social Security Act."

If an intermediary is also administering the Title XIX program for a State, the intermediary will not combine payments under Titles XVIII and XIX in a single check.

## 3705. DENIALS - NOTICE TO PROVIDER

The provider should submit a bill whenever the beneficiary signs a request for payment, even when the provider knows that no payment will be possible.

Whenever the intermediary denies a signed request for payment, the provider must be informed in writing and in detail why no payment will be made.

## 3708. ADJUSTMENTS

If the intermediary notes an error or an item with which it disagrees on the provider bill, the provider will be contacted and the matter clarified. If necessary, the provider will submit a corrected bill to the intermediary.

## 3710. CORRECTED BILLS

When the provider finds it necessary to correct a bill because of an adjustment request or on its own initiative, it will reproduce three copies of the previously submitted bill. Two of these copies will show the necessary corrections and should have the words "DEBIT-ADJUST" printed in large red letters, in the extreme upper right margin. The third copy should be an exact copy of the original bill

and should not show any corrections. This third copy should have the words "CREDIT-CANCEL" printed in large red letters in the extreme upper right margin. The intermediary should submit one of the "DEBIT-ADJUST" copies, and the "CREDIT-CANCEL" copy to SSA, and retain the other "DEBIT-ADJUST" copy for its own file.

If a previous bill requires cancellation only, an exact copy of the original bill should be annotated "CANCEL-ONLY" in red in the extreme upper right margin and transmitted to SSA. The intermediary should annotate its own copy of the bill for its own files.

If the provider submits a corrected bill before payment on the initial bill is made, and the latter amount is determined to be the proper charge, payment will be made on the corrected bill.

However, if the provider submits a corrected bill after payment has been made and the charges on the later bill exceed the charges on the earlier bill, an explanation should be requested from the provider before the additional amount is paid if an explanation does not accompany the bill. If the charges on the later bill are less than the earlier bill, the intermediary should see that the overpayment is recovered from the provider or necessary adjustment made. All adjustments or changes to SSA records will be made by complete credit action first and then followed by the necessary debit action.

#### 3712. OVERPAYMENTS AND UNDERPAYMENTS TO PROVIDERS

The intermediary will determine the amount to be paid periodically to providers of services on an estimated basis. Necessary adjustments with respect to overpayments and underpayments will be made when the actual costs have been determined. While overpayments and underpayments to providers of services will ordinarily be adjusted in this manner, in some situations overpayments or underpayments may be corrected by direct refund or payment if this method is found to be more convenient.

#### 3713. INDIVIDUAL RESPONSIBILITY FOR OVERPAYMENTS TO PROVIDERS

Any payment under the law to any provider with respect to items and services furnished an individual shall be regarded as a payment to the individual. Where more than the correct amount is paid to the provider for items and services furnished to an individual and the Social Security Administration determines that, within a reasonable period (to be specified later), the excess cannot be recouped from the provider, the adjustments will be made by decreasing subsequent social security or railroad retirement benefits payable to the beneficiary (or to his survivors, if the recoupment is not completed before he dies) unless the Administration determines the overpayment is to be waived.



Transmittals to Social Security Administration

## 3801. PREPARING BILLS FOR BATCHING

All staples, paper clips, bands, or other types of fasteners should be removed from the designated copy of the billing form being forwarded to SSA. (Exception: If more than one Form SSA-1483, Outpatient Hospital Billing, is submitted in order to list all the services covered by a single billing, the forms should be stapled together.)

Any case-supporting documents (Report of Eligibility, Utilization Review Notice, developmental material, worksheets, etc.) must be retained by the intermediary with his copy of the billing form. Such material must be available to SSA for audit, survey, or study purposes, however, and thus must be retained in association with the intermediary's case file. (Under certain circumstances, a copy of the Explanation of Accommodation Furnished must be forwarded to SSA. See § 3809 below.)

## 3803. BATCHING BILLS

After claims are completed to payment, whether on an individual case basis, in provider groups, or on some other basis, a batching by types of bills will be made prior to shipment to SSA. Since a given provider's bills will generally fall automatically within a designated category, no extensive sorting or examination of the bills should be required. An intermediary may already have segregated the bills by type to facilitate processing and control within his organization, or may wish to do so to coordinate his control to a greater degree with that of SSA.

Separate the bills to be transmitted to SSA, by type of bills and service, in the following categories:

1. Inpatient Hospital Admission and Billing - Form SSA-1453
- \*2. Outpatient Hospital Billing (Part A) - Form SSA-1483
- \*3. Outpatient Hospital Billing (Part B) - Form SSA-1483
- \*(Note: Where both Part A and Part B services are included on Form SSA-1483, the appropriate copies of the form will be included in each batch. Do not send Part B copies unless there are medical plan charges or Item 21D shows an amount payable.)
4. Home Health Report and Billing (Part A) - Form SSA-1487
5. Home Health Report and Billing (Part B) - Form SSA-1487

6. Inpatient Psychiatric or Tuberculosis Hospital Admission and Billing - Form SSA-1485

7. Christian Science Admission and Billing - Hospital and Extended Care - Form SSA-1486

8. Extended Care Admission and Billing - Form SSA-1478

9. Nonpayment Bills - This category includes bills on which no payments can be made because benefits are exhausted, workmen's compensation paid the entire bill, or services are not covered.

All types of billing forms may be forwarded in the same batch. (These bills will be skeleton bills, i.e., only certain items are to be completed as described in § 3610.)

10. Unmet Deductible - Bills on which no payment is made because charges are less than the deductible are to be batched separately and by type of bill as above for payment bills. Do not include more than one type of bill in each unmet deductible batch.

11. Adjustments and/or cancellations - bills which are being submitted to SSA for adjustment of earlier bills on which errors have been discovered by the intermediary or the provider. Do not include more than one type of bill in each adjustment and/or cancellation batch.

Batch each type of bill in batches of up to 50 bills for transmittal to SSA. Although not more than 50 bills of one type will be included in any one batch, smaller numbers may be transmitted to meet timeliness requirements. However, if you are submitting a number of bills that are not multiples of 50, it is preferable to divide them in two equal batches rather than transmitting one full batch (50 items) and one very small batch. For example, if 60 bills of one type are to be transmitted for the day, divide the bills in two batches of 30 items each rather than in two batches of 50 and 10 items, respectively. Batches of 2 or 3 bills are not encouraged.

#### 3805. TIMELINESS

Since a vital feature of the entire program is the timely recording of the utilization data as shown on the billing forms, batches of bills should be forwarded as often as possible, preferably daily. Those intermediaries handling a high volume of particular types of bills will be able to ship full batches regularly without experiencing difficulty in accumulating bills to comprise full batches.



Even where a low volume of a particular type of bill is handled, bills should not be retained on the expectation of additional bills to enlarge the batch; timely filing is more important than size of shipment, even though very small batches (§ 3803 above) are not encouraged.

On the last day of the calendar month all outstanding batches should be transmitted to SSA. Bills for which reimbursement has been made in the current calendar month should not be intermixed and transmitted in a batch with bills that will be paid in the next calendar month.

#### 3806. TRANSMITTAL AND CONTROL OF BILLS

Forward each batch shipment to SSA under cover of a transmittal, Form SSA-1559 (see Exhibit 1). The SSA-1559 should be prepared in duplicate with the original accompanying the batch shipment to SSA and the duplicate retained as the intermediary's record of shipment. Enter the following information on the SSA-1559 in the appropriate spaces:

1. Intermediary identification number (as assigned by SSA).

NOTE: If an intermediary has more than one paying office capable of submitting bills directly to SSA, individual intermediary numbers must be established and assigned to each office by SSA before SSA will accept bills from other than the parent office. Bills submitted prior to the assignment of a number to the paying offices will be returned to the parent office.

2. Intermediary's name and address.

3. Batch number. A consecutively assigned 3-digit number beginning with 001 and running through 999, and then repeated. The number should be assigned consecutively regardless of the type of batch; i.e., not a separate series for each type of bill. If an intermediary has more than one paying office submitting bills directly to SSA, each individual office must maintain separate consecutive batch numbers for the bills they submit.

4. Date batched (enter the shipment date of the batch).

5. Type of bills included in the batch. Enter the form number of the bills included in the batch. Also, in Outpatient Hospital Billing (Form SSA-1483) and Home Health Report and Billing (Form SSA-1487) batches, Part A and Part B batches should be so indicated by showing the form number followed by "A" or "B," as appropriate. For nonpayment batches show, "Nonpayment" with no



form number indication. Batches of unmet deductible billing forms will be designated "Unmet Deductible" with the appropriate billing form number indication. For adjustments and/or cancellation batches, show, "Adjustments" as well as the billing form number.

6. Total number of bills included in the batch. This number should represent the total pieces of paper in the batch. For example, in "Adjustment" batches, a copy of the originally submitted bill will be included with the adjustment bill. These should be counted as two bills even though they are to be processed as plus and minus actions for the same account. However, if it is necessary to submit more than one Form SSA-1483, Outpatient Hospital Billing, in order to list all the services covered by the bill, the Forms SSA-1483 should be stapled together and counted as one bill.

7. Total amount of reimbursement represented by the batch. Credit and debit adjustments should be processed as plus and minus money amounts when determining the total amount of reimbursement. For unmet deductible or nonpayment billing form batches, enter "Unmet Deductible" or "Nonpayment" in this space.

After completing the transmittal, a final check should be made to ensure that each batch is assembled properly and contains only the items (types of bills) that are indicated on the covering transmittal. In addition, a final check should be made to ensure that each bill contains the signature of the intermediary official approving the bill and the date of approval. Absence of this information will result in the bill being deleted and returned to the intermediary by SSA.

SSA will utilize the consecutively assigned batch numbers as a control to ensure that all batch shipments are received. Skipped batch numbers, unless explained on the transmittal accompanying the next shipment, will result in an inquiry to reconcile the omitted numbers. Likewise, duplicate batch numbers will result in an inquiry to reconcile the duplication. In these cases a new batch number will have to be assigned.

SSA will return a copy of each batch transmittal, Form SSA-1559, to the intermediary after all items have been processed. (See § 3812 for an explanation of the handling of items which could not be processed.) The transmittal will indicate the number of items processed and the reimbursement amount processed to SSA records.

A batch number will also be utilized in the reconciliation of shipments with the letter-of-credit reporting procedure, and for reference purposes in any contact or correspondence regarding discrepancies in

batch-balancing processes. A register or reference list of batch numbers (duplicate SSA-1559's) and related data should, therefore, be maintained by the intermediary.

### 3808. PACKAGING AND MAILING OF BILLS

More than one batch of bills may be included in the same package for mailing purposes, but each batch must be separated, with an appropriate covering transmittal, Form SSA-1559. All bills should be packaged securely so that mutilation or other damage to the bills during mailing will be kept to a minimum. All bills should be sent by Air Express (where applicable) to:

Social Security Administration  
Bureau of Data Processing and Accounts  
P.O. Box 26  
Baltimore, Maryland 21203

### 3809. TRANSMITTAL OF EXPLANATION OF ACCOMMODATION FURNISHED (FORM SSA-1484)

Where the intermediary determines that assignment to ward accommodations was not at the patient's request or was not consistent with the purposes of the Social Security Act, he retains one copy of Form SSA-1484 in his file and transmits the other to SSA. Use the transmittal, Form SSA-1559, to forward such forms separately to SSA. Do not show a batch number. Complete the intermediary identification items and enter "Form SSA-1484" in the type of bill space. No other entry is necessary on the transmittal form.

The transmittal may be included with a package of bills, or mailed separately to the address in § 3808. If mailed separately, use regular mail.

### 3812. DISCREPANT BILLS IDENTIFIED BY SSA

Occasionally it may be necessary for SSA to return batches of bills, or individual bills, to the intermediary because of discrepancies in batch totals, or in particular items on the bill. To ensure that the individual bills are returned into the processing system to update the utilization records, any such cases will be identified by SSA. As a part of the normal confirmation of receipt process, (§ 3806 above), all bills, or batches, returned to the intermediary for reconciliation of discrepancies will be returned with a copy of the Form SSA-1559 which accompanied the batch to SSA. The SSA-1559 will be annotated to show those bills being returned to the intermediary and the previous transmittal totals will have been adjusted to show the number of items and the amount of reimbursement actually processed by SSA. If the entire batch requires return, the SSA-1559 will merely be noted to indicate the return of all bills included in the batch.



The intermediary should expedite resolution and rebatching of such cases and adjust his records accordingly. If an entire batch has been returned, a new batch number must be assigned to the batch before it is returned to SSA for processing. The individual reconciled bills may be included in the appropriate type of batch for return to SSA in the next regular shipment.

#### 3814. OTHER ACTIONS AND MATERIAL

In addition to bills removed from the processing system prior to the updating of the utilization records, certain bills may be returned to the intermediary after the completion of all SSA processing. Such bills could involve requests for development or investigation of some aspect of the bill or verification of certain data. SSA will clearly identify and distinguish each of these bills from those which must be re-entered into the processing system for updating purposes.

After the intermediary's action is completed, such bills should be returned to SSA as individual items and not included in a batch of regular bills. Although the material may be mailed in the same package with a shipment of regular bills, these bills should be clearly identified as not requiring processing. Generally, such bills should be returned by letter mail to the organizational component which requested the action.

#### 3816. ADJUSTMENTS AND/OR CANCELLATIONS BY THE INTERMEDIARY

Occasionally the intermediary may find that bills previously submitted and completely processed through SSA's system, are incorrect. In these cases adjustment or cancellation of the previously submitted bill may be required.

A copy of the originally submitted bill, acceptable for filming purposes (see below), must be prepared and forwarded to SSA for each adjustment or cancellation action. In those cases requiring adjustment of previously submitted bills, the copy of the original bill must be printed with the words "CREDIT CANCEL" in large red letters, in the extreme upper right-hand corner of the bill. The corrected bill, which should accompany the cancellation, should be printed with the words "DEBIT ADJ." in large red letters, in the extreme upper right-hand corner of the bill. If a previous bill requires cancellation only, the copy of the original bill should be annotated in the extreme upper right-hand corner with the phrase "CANCEL ONLY."

It is imperative that every bill sent to SSA as a cancellation action be an exact duplicate of the originally submitted bill. Only information shown on the "Debit Adjustment" may differ from the original bill. "Credit Cancel" or "Cancellation Only" bills which appear to



differ from the original will be returned to the intermediary for an explanation and resubmittal.

Because all claims forms must be acceptable for microfilming by SSA, only copying machines which produce clear copies may be used in preparing copies of the original submitted bill. If the print is light or blurred by the copying process, a typed copy will be necessary.











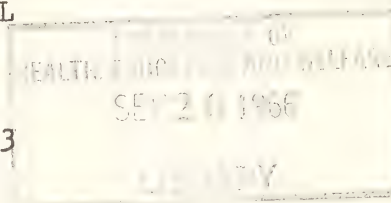
DEPARTMENT OF HEALTH, EDUCATION, AND WELFARE  
SOCIAL SECURITY ADMINISTRATION  
BALTIMORE, MARYLAND 21235

September 23, 1966

PART A INTERMEDIARY MANUAL

HIM-13 - Part 3

REVISION TRANSMITTAL NO. 3



<u>New Material</u>	<u>Page No.</u>	<u>Replaced Pages</u>
Sec. 3113 (Cont'd) - 3115.1 (Cont'd)	39-40.1	39-40

This revision makes the following changes:

Section 3115 has been changed to emphasize that payment may not be made under Part B for hospital services furnished to inpatient beneficiaries who have exhausted their inpatient benefit days or who otherwise lack entitlement to have payment made for such services under Part A.

Section 3115.1 has been revised to incorporate the modified definition of physicians' supervision in determining hospital services incident to physicians' services, which was contained in Intermediary Letter No. 127.

Arthur E. Hess, Director  
Bureau of Health Insurance

Action Note: To § 3112, add cross-reference to § 3115.1.

PART A INTERMEDIARY MANUAL, HIM-13 - PART 3,  
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B. Drugs and biologicals necessary for diagnostic study (see § 3101.3 for definition of drugs and biologicals);

C. The services rendered in connection with a diagnostic study by an intern or resident-in-training in an approved teaching program (if not under an approved teaching program, see § 3115.1C);

D. Other services and supplies if customarily furnished to outpatients for purposes of diagnostic studies.

If the beneficiary has coverage only under the medical insurance plan, payment for the diagnostic services can be made under Part B. (See § 3115.2 for Part B diagnostic services.)

3113.1 Outpatient Hospital Diagnostic Study Period.--A diagnostic study is a period of 20 consecutive days beginning with the first day, not included in a previous diagnostic study, on which the patient is furnished outpatient hospital diagnostic services. The diagnostic services furnished during the study must be furnished by or under arrangements made by the same hospital. A subsequent study may not begin in or under arrangements made by the same hospital until the prior study has been completed. However, two or more studies may be conducted concurrently in different hospitals. The study ends after 20 days regardless of the number of days on which diagnostic services were actually furnished. Diagnostic services which continue beyond 20 days are considered to be in a new study period and must be separately billed.

#### Hospital Services Covered Under Supplementary Medical Insurance

##### 3115. COVERED SERVICES

Payment may be made under the supplementary medical insurance plan for certain outpatient hospital services. (Payment may not be made under the supplementary plan for hospital services which would otherwise constitute inpatient hospital services, extended care services, or home health services.) Thus, for example, payment may not be made to a hospital under Part B for diagnostic x-rays, laboratory services, x-ray therapy, or other services furnished to inpatients when the beneficiary remains an inpatient after exhausting his 90 days of coverage in a spell of illness. Payment under Part B for services rendered to inpatients is also precluded when no Part A payment may be made because the services do not meet the special requirements for coverage of services received in a psychiatric or tuberculosis hospital, or the hospital is not a participating provider of services. This exclusion applies only to Part B hospital services and does not prevent reimbursement for physicians' services rendered individual beneficiaries in a hospital.

Items or services furnished by others under arrangements with the hospital must be furnished in accordance with the requirements explained in 3007.

3115.1 Services and supplies (including drugs and biologicals which cannot be self-administered) incident to physicians' services rendered to outpatients of hospitals are covered. (See § 3030 for definition of physician.)

A. Hospital Services Incident to Physicians' Services.--When services are provided in the outpatient department of a hospital, there is assurance of medical management of the services either through direct supervision by the physician ordering the services or supervision by the hospital's medical staff. Therefore, all services provided by the hospital in connection with the physician's diagnosis or treatment of outpatients are incident to his services. This includes the use of the hospital's facilities, the services of nurses, technicians, therapists, and other aides. There is no requirement that the physician who orders the hospital services be directly connected with the department which provides the services. When such hospital services are diagnostic, they are covered under Part A, (see § 3111); all other services are covered under Part B.

If hospital personnel provide services outside the hospital premises, the services are covered as incident to physicians' services only if there is direct personal supervision by a physician. For example, if a therapist goes to a patient's home to give treatment and no physician accompanies her, the services would not be covered. (Such a service would be covered as a home health service if provided as part of a home health plan under arrangements with a home health agency.)

Generally, the only services provided in the outpatient department of a hospital which are not incident to physicians' services are those which do not require participation by hospital personnel acting under specific order by a physician. Such a situation would arise when a hospital makes certain equipment, such as an intermittent positive pressure breathing machine or exercise equipment, available to the patient who is able to use it without assistance or instruction.

B. Supplies incident to physicians' services are those necessary to the physicians' services in the outpatient department, e.g., surgical supplies, surgical dressings, the use of an emergency room, cast room, and operating room for minor surgery.

Drugs and biologicals administered to outpatients must be of the type which cannot be self-administered. These are generally limited to those administered by injection, including those required on a continuing basis, such as for pernicious anemia or arthritis. However, if the injection is of the type which is commonly self-administered, such as insulin injections, the drug or biological is excluded unless it is administered to the patient in an emergency situation. (For definitions of drugs and biologicals and combination drugs, see § 3101.3.)

Whole blood administered to outpatients is covered as a biological which cannot be self-administered and reimbursement is not subject to the whole blood deductible. (See § 3205.)

Payment may not be made for immunization, i.e., vaccination or inoculation against diseases such as smallpox, polio, diphtheria, etc. "Immunization" for this purpose, however, does not include a vaccination or inoculation related to the treatment of a particular injury or direct exposure, e.g., antirabies treatment, tetanus antitoxin or booster vaccine, botulin antitoxin, antivenin sera, or immune globulin.

Prescription and nonprescription drugs and biologicals purchased by or dispensed to a patient are not covered.













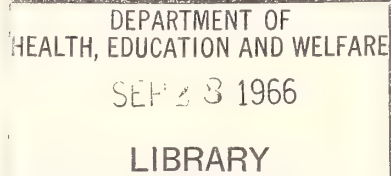
DEPARTMENT OF HEALTH, EDUCATION, AND WELFARE  
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PART A INTERMEDIARY MANUAL

HIM-13 - Part 3

REVISION TRANSMITTAL NO. 4



<u>New Material</u>	<u>Page No.</u>	<u>Replaced Pages</u>
Table of Contents, Chap. VII	173-174	173-174
Sec. 3618	182.1-182.2	

Section 3618, Fraud in Connection with Claims, has been added. This section sets forth the guides for identifying and handling claims with possible fraud implications.

Arthur E. Hess, Director  
Bureau of Health Insurance

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# CHAPTER VII

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## 3618. FRAUD IN CONNECTION WITH CLAIMS

Section 208 of the Social Security Act, which provides penalties for fraud and misrepresentation in connection with claims for benefits, is generally applicable to the health insurance program. The procedures for processing health insurance claims should insure that payment is made only for covered services furnished to health insurance beneficiaries; however, it is recognized that these procedures cannot be one hundred percent effective. Sanctions provided under section 208 of the Act will be applicable in any case in which it is found that a person attempted, by fraud or misrepresentation, to obtain services or payment under health insurance.

While the Social Security Administration has the responsibility for undertaking the necessary development in any case in which fraud or misrepresentation is indicated, the intermediary has a basic responsibility for recognizing possible fraudulent claims and calling them to the attention of the Social Security Administration. Where cases of fraud or misrepresentation are uncovered, the intermediary is to withhold payment to a provider, beneficiary, or other person as the case may be, until the Social Security Administration has had the opportunity to investigate the matter.

Intermediaries should be alert to recognize fraudulent claims; however, they should guard against a posture in which all claims are viewed as suspect. Fraud is expected to occur only in a very small percentage of cases. Intermediaries must distinguish between deliberate fraud and erroneous claims based on mistakes or misunderstanding of the law. It is likely that many persons have some misunderstanding of who may be entitled to benefits and what services are covered under the health insurance program.

Incidents which might possibly show indications of fraud may include claims in which the alleged services would not have been appropriate in the treatment of the illness; contacts by beneficiaries who, after receiving utilization notices, deny having received some or all of the services for which payment was made under the health insurance program; altered bills and receipts; etc. In these or similar situations, the intermediary should first verify routinely that no clerical error or genuine mistake was involved in making the claim. Where it appears that there may have been an attempt to claim benefits by fraud or misrepresentation, a report should be sent to the Social Security Administration for further investigation. These reports should be directed to the attention of the Social Security Administration, Bureau of Health Insurance, Division of Health Insurance Policy and Standards, Room 4-R-2, Baltimore, Maryland 21235.

Administration experience has shown that we can expect to receive occasional signed and unsigned allegations indicating that a particular individual received benefits to which he was not entitled. In these cases, the intermediary should limit its investigation to verifying that a claim for benefits was made by the individual as alleged, and a report, containing the facts in the case, along with the statements in evidence, should be forwarded to the Bureau of Health Insurance at the address above.























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